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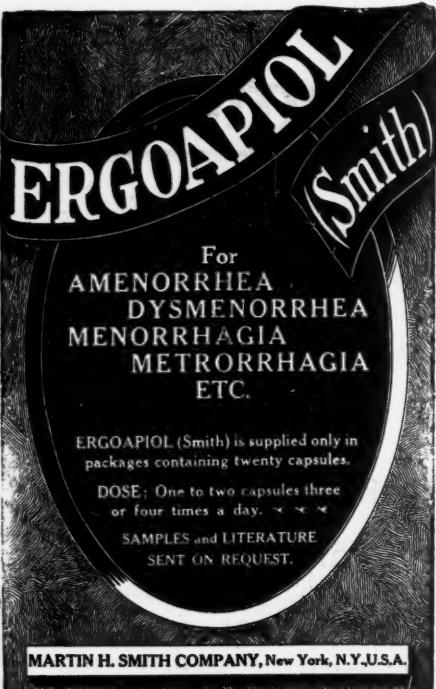
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VOL. I.—8TH YEAR.

SYDNEY: SATURDAY, APRIL 9, 1921.

No. 15.

OBSERVATIONS ON SOME PRINCIPLES GOVERNING MODERN MIDWIFERY PRACTICE.

By Margaret McLorinan, M.B., Ch.B. (MELB.),
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for Women, Melbourne.

Introduction.

By far the most important problem of modern medicine is the fatality and morbidity associated with the function of reproduction of the species involving, as it does, the lives of two separate individuals. The birth of the child can no longer be called a normal function, inasmuch as we have set ourselves an ideal and that is to conduct the woman safely through pregnancy and labour so as to gain a living healthy child capable of extra-uterine existence and to return the mother as far as possible to the same health as formerly. Can anyone say that this is the general rule and that an abnormal midwifery is exceptional? One has only to investigate the records of the out-patients department of any hospital to find support to the fact that more than half the women are permanently damaged by the so-called normal function of bearing a child. Apart from the introduction of the antiseptic system, we cannot say that during the last 25 years any great advance has been made, since such so-called advances as "twilight sleep," narcotics and anaesthetics merely palliate what to the modern woman has become a nightmare. Speaking generally the smaller the child, the easier the delivery and the longer the normal child remains *in utero* beyond the eighth month, the greater the difficulty, so that the question is raised whether the retention of the foetus *in utero* beyond the eighth month is actually pathological rather than physiological. This raises the two questions: (i.) When is the fetus full time? (ii.) What factor or factors are necessary to initiate its expulsion from the uterus? Round these questions hinges in my opinion the whole future of midwifery and in an endeavour to throw light on them I wish to refer to two cases that occurred within a few weeks of each other in my own practice.

CASE I.—A primipara, *etatis* 34 years, was first seen when eight weeks pregnant, when the uterus was found to be retroverted and was replaced. Pregnancy proceeded uninterruptedly till the seventh month. Some slight oedema of the hands and feet was then noticed, with a slight trace of albumin. She was placed under treatment for this and carefully watched. Progress was satisfactory till 8½ months, when I noticed that no presenting part was settling into the pelvis. As full time approached and evidence of kidney failure increased, she was sent to a nursing home and kept under close observation. The albumin did not disappear from the urine, neither did any portion of the foetus settle into the pelvis. After her due date was reached, I attempted to induce labour by simple means, such as quinine given in repeated doses and *ol ricini*, with no result; the presenting part remained high above the brim of pelvis. The patient was rapidly becoming more "toxic," the quantity of albumin in the urine increased from a trace to 25% by volume of albumin, then to 50% (Esbach); the urine greatly diminished in amount, acetone and diacetic acid appeared, while the oedema increased. It was, therefore, useless under the stress of these urgent symptoms to await further the onset of labour. Cæsarean

section was undertaken with a successful result, the baby weighing over 4 kilograms. Soon after the operation the mother began twitching and became restless and irrational; morphine was given and a fit averted. On the morning of the operation the urine contained 75% by volume of albumin (Esbach) and this remained for six hours. The albuminuria then cleared up. The general symptoms soon disappeared and the patient made an uninterrupted recovery. Pelvic measurements were slightly diminished, but not markedly so.

CASE II.—A multipara, *etatis* 32 years, had had a previous normal pregnancy. According to calculations, labour did not start till six weeks after due date. As I had attended her at her previous confinement, no concern was felt. In a few hours after onset of labour pains, the os was fully dilated. After waiting for some time, as no descent was taking place and the presenting part, lying in the normal, left occipito-anterior position, was very high up in the pelvis, forceps were applied. A long and difficult pull allowed the delivery of a large head; the child was alive, but the cord was twice round the neck. The shoulders then became impacted and it was only after deep anaesthesia and dislocation of one shoulder that the combined efforts of myself and an assistant resulted in the delivery of an asphyxiated child weighing 5.67 kilograms. The mother made an uninterrupted recovery.

Résumé of Foregoing Cases.

In Case I. the operation of Cæsarean section undoubtedly saved the lives of both mother and child. This treatment, however, can only be regarded as a stop gap, since it brings us no nearer the cause of failure of the labour. The disproportion between the maternal pelvis and the foetus, in my opinion, might have been overcome during labour, but the onset of urgent eclamptic symptoms made further delay impossible.

In Case II. a premature induction of labour or Cæsarean section would have undoubtedly saved the child, but there was nothing to indicate that such procedures were justifiable. The child should have been regarded as full time many weeks before its actual delivery and the ideal treatment would have been to assist in some way Nature's failure to effect normal uterine dilatation and delivery. In fact, I would regard its final two month's retention *in utero* as useless and pathological. From the eighth month onward, there was a failure on the part of Nature to initiate labour so as to effect delivery of a normal fetus.

General Consideration.

Is Abdominal Delivery on the Increase?

It cannot be denied that compared with twenty-five years ago Cæsarean section to-day is a frequent operation. Formerly its great use was in deformed and contracted pelvis, but to-day it is often used in cases of eclampsia, in which the coarse mechanical means of inducing labour are inadvisable owing to their exhausting effects. Thus eclampsia and the necessity for Cæsarean section may be dependent on the abnormal retention *in utero* of a viable foetus as the result of failure on the part of Nature to initiate labour.

Why is Modern Labour Becoming Abnormal?

Given a normal female pelvis the failure to effect delivery can be ascribed to the size of the child, which is tantamount to saying that the foetus has been abnormally retained too long *in utero*. We have

no positive evidence that within the last 100 years the average size of the female pelvis has increased. On the contrary, as development of bone is largely dependent on muscular action, the reverse would appear to be the case. Unfortunately, the same cannot be said of the fetal head. Herein, in my opinion, is the great cause of difficult labour. The increase in intellectual development of the modern human has resulted in a corresponding increase of neopallium—the epencephalon of Lamarck. Function is succeeded by structure and to this there can be no limitation. But we know of no law defining a correlation of increased development of the female pelvis with increased development of the fetal head, *i.e.*, of intellectuality. Nine months is becoming too long a period for the fetal head to be retained *in utero*. The advantage of an extra month to the foetus cannot be reconciled with the disadvantage to the mother.

When is a Pregnancy "Full Time"?

So far we have no scientific way in which we can tell when expulsion of the foetus should or is about to take place. Our unscientific present-day standby is still the ready reckoner. In Case II., where everything apparently was normal, I waited on Nature to initiate labour as manifested by the onset of pains. The mathematical calculation was "wrong," because it did not coincide with the time she chose to initiate labour. I feel now that the delay was pathological. In what we regard as a normal case, we may have at the eighth month indications of commencing labour which at present we are failing to recognize. We presume that the onset of pains is correlated to our ready reckoner. There must surely be some other scientific sign of commencing labour than the onset of pains to tell us that the foetus is "full time." By the recognition of this sign our ideal would be to assist Nature to deliver an earlier and viable child and so to lessen the maternal risks through surgical interference at a later date.

How is Labour Initiated?

If the clue to this could be discovered, we would have the key to many problems that at present baffle and bring discredit to obstetricians. Our internal drugs to initiate labour are unreliable and the methods of dilating the lower uterine segment by mechanical means are coarse. Pituitary gland extract we know to be useful in strengthening and increasing uterine contractions once they have begun, but in itself is of no use in starting labour. Some match has still to be discovered that sets the process alight. The extraordinary and selective effect of the endocrinological pituitary gland or diminution of some hormone circulating in the blood from some ductless gland or glands may be responsible for the differences we find in our midwifery cases. In the solution of this problem comparative anatomy should offer us a clue.

Comparative Physiology.

The discovery of three new glands in the platypus (*mammalia*)¹ was announced before the Royal Society in Melbourne in 1918, *viz.*, shoulder, parathymus and scapular glands. Two of these, *viz.*, the shoulder and parathymus, have also been observed in mar-

supilia. It is also worthy of note that in the adult female wombat (*Phascolomys mitchelli*) a well-defined firm body (Figure I.) is noted in connexion with each ovary, showing histologically the typical structure of a *corpus luteum*. This represents, undoubtedly, the greatest development of luteal structure found throughout mammalia.

Furthermore, diversity of structure is found in the Australian mammals amongst other glands, as regards, for instance, the adrenals and the thyroid gland. A study of the mammals leads us to the conviction that the science of endocrinology is only in its infancy. The physiological experiments now being conducted at the Australian Institute of Anatomical Research in Melbourne in reference to this subject are awaited with no little interest.

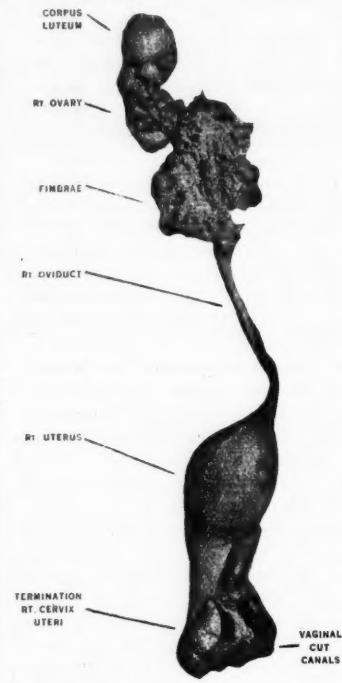


FIGURE I.
Dissection to show Ovary and Uterus, right side, from a Victorian Wombat, with a Young in Pouch.



FIGURE II.
Young Wombat in Pouch.

¹ "The Comparative Anatomy of Australian Mammals," Vol. III.; "The Glandular System in Monotremes and Marsupials." (From the Australian Institute of Anatomical Research.)

The Marsupial Birth.

If we take two animals low down in the mammalian scale, such as the wombat and the kangaroo (*marsupialia*), we find the conditions present for an easy birth, *viz.*, a roomy pelvis and a small fetus. The retention *in utero* of the fetus of these animals probably varies from 24 to 34 days. The illustration shown (Figure II.) is of a fetal wombat shortly after its birth and its having been placed by the mother on the nipple. Its actual length was only 2.5 cm. It had perfect muscular movements in response to stimuli and was alive four hours after the death of the mother. It almost seems incredible that extra-uterine existence is possible at such a minute stage and yet such a fetus can develop into an adult animal regarded as "the most perfect physical type amongst mammals," with a well-developed neopallium. No instances of monstrosities have been recorded amongst the wombats. A prolonged intra-uterine existence is unnecessary for the development of this animal's neuromuscular system.

TEAM WORK IN SANITATION.¹

By W. A. Sawyer, M.D.,

Senior State Director, International Health Board, Rockefeller Foundation; Director, Australian Hookworm Campaign.

In sanitation, as in sport, team work is the organized effort of a group to achieve a common object. It is inherent in the very idea of sanitation, the application of which is usually a community or national affair.

"Team work" means good leadership, complete organization and enthusiastic co-operation. It gives effectiveness to the group far above the sum of the greatest possible accomplishments of the individuals. It suggests a definite goal which every member of the team is straining to reach for sheer love of victory and the game.

In sanitation team work may be brought about by military organization and be supported from a distance, as in army camps or the Panama Canal zone. As a rule, however, sanitation depends entirely upon the support of the people benefited. Under these conditions it is fundamental to successful and sustained team work that the public be kept informed and that the value of health protection be continually demonstrated by exhibitions of good team work and its results.

In the hope of starting a fruitful discussion by those of more experience, I shall present what seem to me the essentials of good team work in sanitation.

There must be specialization—good training of different sorts. Every man must have a part which he can play excellently and in addition he must understand how his part and those of his team mates supplement each other.

The decision as to what kinds of players are needed to make up a balanced team must depend on the nature of the public health problem. For general health work the services of administrators, epidemiologists, sanitary engineers, chemists, bacteriologists, vital statisticians, public health nurses, medical school

inspectors and other specialists are usually required. We must not forget the all-around-sanitarians at the outposts—the local officers of health.

The second essential is sufficient size of the organized health group. The individual does not get very far in sanitation because he cannot control his neighbour. The small community cannot afford the specialization so essential to an adequate health team and it must look to the State or district for much of its expert service. There are also health problems which can best be handled by a nation as a whole, as, for example, the control of diseases threatening the entire country and entrenched in a region financially unable to carry the entire burden of control measures, the supervision of interstate and international quarantine, the licensing of laboratories to manufacture biological products for interstate or international trade, research of general bearing and phases of popular education in health matters. The optimum size of the group depends on the specific problem to be attacked, but the present day tendency is toward larger organized groups. It is as futile for a city to attempt the work of a state or for a state to do the work of a nation as for the individual to attempt single-handed to protect himself and his family from communicable diseases.

Even nations cannot live to themselves in health matters and it is encouraging to read in the newspapers that the League of Nations regards the establishment of a department of health as one of its first duties. Imagine the world working together in controlling tropical diseases or world-wide epidemic diseases, or in handling international quarantine on a co-operative basis! That would be team work on a colossal scale. If true team work is developed, the results will be magnificent.

The third essential is leadership. Good leadership inspires confidence and spurs to effective action. It co-ordinates the work of the specialists and it holds the group together. It crystallizes the spirit of the team and points to the goal for which the team is fighting. It stimulates loyalty to that abstract thing—the team. Without good leadership there can be little enthusiasm and without enthusiasm a team is a lifeless thing.

The fourth and last essential has almost been anticipated. It is *esprit de corps*, a burning consciousness of the team and pride in it. The man who has gone into public health work, should realize that he has entered a profession equal to any. Public health should seem to him a super-profession to which the others are but preparatory.

But how can a man feel that way about public health if the team is never called together, if it is ill-defined and if he seldom hears about it or about the other members? Moreover, work essential to public health is carried on under other banners than that of sanitation. Those doing the work are not fully conscious of their relationship to the cause of public health. *Esprit de corps* is necessary for each sharply-defined working team, governmental or otherwise. It is equally important for the great body of public health workers of Australia, regardless of their connexion with this service or that.

Among public health workers we are too prone to overlook some very important groups—statisticians,

¹ Read before the Section of Public Health of the Australasian Medical Congress, Brisbane, 1920.

engineers, medical men, nurses—outside the regular health departments; for example, the State Registrars and their assistants specially occupied with vital statistics, the sanitary engineers connected with water and sewerage boards, physicians, nurses and dentists doing work in preventive medicine under departments of education or non-official supplementary health organizations and the officials, statisticians and health workers of life insurance companies. In the American Public Health Association corporate memberships are held by life insurance companies and high offices have been occupied by their representatives. The business-like way in which these men look at our common problem of lowering the death rate, is an inspiration to those of us professional men whose training was, to say the least, not very strong in statistical methods and business procedure.

The *esprit de corps* of all public health workers as a body cannot be obtained by mere theorizing. The self-consciousness of so large a group must be artificially stimulated. There are too many members—and they live too far apart—to be called together in frequent conference or to meet freely in connexion with their work. The obvious medium would be a publication, no matter how humble at the beginning, which would come regularly and often to remind each worker that he is a member of a team that is putting up a strong and winning fight for longer lives and happier ones for his countrymen. A monthly instalment of items of scientific and personal news would be stimulating and of greatest help to the more isolated workers. Even the larger business houses have found that they can create *esprit de corps* by circulating a "house organ" to their factory and office employees and travelling men.

It also helps keep us humble and ambitious to learn of the big things others are doing in public health. An isolated egotist in public health work may become a positive danger to the public. The man who feels permanently and fully qualified as a sanitarian, because he possesses a medical education and a text book or wears a sanitary inspector's badge and has a travel allowance, will not give or receive much useful co-operation; neither will the individual who is temporarily in public health work by condescension. The distorted vision of both is largely due to isolation and should be corrected.

A type-picture of modern team work in sanitation is presented by the epidemiologist and the laboratory and field workers assisting him. Imagine a sudden outbreak of disease which is not understood by the local medical officer of health. The practising physicians are in disagreement even as to the diagnosis, and there are most extravagant theories abroad as to causation. The epidemiologist arrives on the scene. He looks like one man, but he is really the captain of a team. He does not look about, see an open privy and some flies, announce to the papers that the flies are to blame and should be swatted and then hasten to catch the train so as to be home in time for dinner. No! He visits physicians and patients and inspects premises and takes notes and draws diagrams and sits up to night-time putting two and two together to make four. At the same time he sends specimens to his team mates at the labora-

tory and wires his department for inspectors or engineers, if he needs them. The laboratory staff is also sitting up at night-time to plant cultures and identify organisms; the messenger boy stays overtime to wrap bundles and wait for telegrams. And finally the two of the field workers plus the two of the laboratory workers do make four and the results are announced. Then the epidemiologist returns to his headquarters at the laboratory. No one greets him with a complaint about the number of specimens sent in and the work overtime and broken theatre engagements. On the contrary, it is all congratulations and the victory belongs to the team and to every member of it.

I have in mind an example of team work between a State board of health and a university. The board longed to keep its practical health work on a high scientific plane, but it was unable to maintain a permanent staff of entomologists, helminthologists and protozoologists of the first rank. On the university teaching staff were men of highest skill in these lines, but chafing for opportunities to make direct application of their knowledge for the public welfare. And so the State board gave certain of the professors and inspectors nominal appointments as consultants in this or that specialty and paid all the costs of their work in directing malaria and mosquito surveys and investigations into the varieties of intestinal and protozoan parasites. The results were most satisfactory to everyone concerned and beneficial to the public, because there was a true spirit of team work.

A similar bit of team work has been organized by the Commonwealth Quarantine Service and the Hookworm Campaign. The Quarantine Officers at Darwin and Thursday Island have been appointed Medical Officers of the Hookworm Campaign, without additional salary, for the purpose of investigating hookworm infection in the vicinity of their posts. The Hookworm Campaign pays the incidental expenses and salaries of necessary assistants. By such co-operation the work of the Hookworm Campaign is advanced more rapidly and much travel and salary expense is saved to the taxpayers. But the co-operation is not all on one side. The Medical Officers of the Hookworm Campaign have been gazetted as Commonwealth Quarantine Officers and given preliminary instructions, so that, in a grave health emergency, the entire organization of the Hookworm Campaign, or any part of it, can be temporarily absorbed into the Quarantine Service on telegraphic notice. I am sure that the medical officers are glad of the opportunity to give additional service to the Commonwealth by standing ready for emergencies.

Another example of successful team work deserves special mention. In the earlier hookworm investigation in northern Queensland the State Department of Public Instruction placed printed information about hookworm and its prevention in the hands of teachers and pupils and also detailed a trained nurse to co-operate by making mental tests of children in certain infected areas. It was these tests which demonstrated so conclusively the serious mental retardation due to hook worm in school children. Without the hearty co-operation of the Department of Public Instruction this important work would not have been accomplished,

Departments of education, universities and private schools can do much to co-operate with health departments by teaching the children how disease is prevented. The educational and public health organizations between them should leave no void of ignorance of biology and sanitation to be filled with misinformation about health. But there must be team work or else controversy and failure.

Once I had a close view of team work between a large organization of women and a state board of health in bringing about pure milk legislation. It was a modern milk law they were fighting for and it practically meant state-wide pasteurization of milk under the supervision of health departments and grading on the basis of dairy inspection and bacterial counts on delivery at the pasteurization plant and again at the customer's house. Before the women were through, the legislators were horrified at the thought of sediment in milk and dreamed at night of dead babies. Of course the bill passed and it enabled one to open a bottle of "grade A" pasteurized milk, knowing that the contents had not been exposed to contamination from the time the bottle left the pasteurizing plant till the cream was poured off at the breakfast table. That was radical legislation and it took real team work to bring it about. But it was worth while to make it possible for all the people to get clean, sweet milk at ordinary prices and to give the poorest baby the same safe food as the rich man's child.

It is superfluous to talk about the co-operation of physicians, nurses and dentists in sanitary work. They are obviously parts of the local groups working for the public health. Those that are not, should be. And as for the co-operation between State Health Departments and the Hookworm Campaign, their relations are so close that you can hardly tell where one begins and the other leaves off. Australia knows how to do team work.

In my opinion Australia is ready for a public health revival. The people are most interested in public health. In fact, they have traditions of sanitation running back through generations. They are also remarkably free from health fads and organized ignorance in health matters. Where you find lack of information you also find a hunger for the facts and a reasonable respect for scientific authority. One of the Medical Officers of the Hookworm Campaign complained that he had to repeat a lecture because the hall would not hold the crowd. Think of people crowding to hear a public health lecture!

The Australians I have met have a common desire to perfect their sanitation. They want to know: "What must be done and who will do it?" The press seems to say: "Tell us what ought to be done, so that we can advocate it before the people." The newspapers have co-operated splendidly with the Hookworm Campaign.

This meeting, the first after the long interruption by war, may well be the mile-stone that marks the beginning of a more rapid development of team work in sanitation—team work of so high an order that preventable disease, in the tropics and elsewhere, will be brought rapidly under control. Then "sanitation" would regain its true meaning in Australia

and would cease to be to many merely a euphemism for night-soil disposal, however insanitary. Then would the people appreciate fully the benefits which may be derived from team work in sanitation.

Reports of Cases.

NOTES ON A CASE OF HYDATID OF THE HEART.

By R. Humphrey Marten, M.D. (Cantab.),
Adelaide.

PATHOLOGICAL REPORT.

By C. T. C. de Crespigny, M.D., M.R.C.P. (London),
Honorary Physician, Adelaide Hospital.

When I first joined this society, now some thirty-two years ago, reports of cases of hydatid disease and discussions on their treatment were of almost monthly occurrence and anyone who would take the trouble to peruse the earlier transactions of the Australasian Medical Congresses, would find much food for thought on echinococcal infections.

It is now some years since we had much to say or hear of this disease, so I thought it might be of some interest to you if I reported a case of hydatid disease of the heart which was recently under my care, not only because it is a case of great rarity, even in this country, but because it shows how much we are indebted to the use of X-rays in the diagnosis of obscure intra-thoracic diseases.

Dr. Davies Thomas, writing in the later years of the last century, said that 48 cases of hydatid disease of the heart had been reported; out of 2,000 cases of hydatid disease the heart and organs of circulation were invaded in only 1.845%.

Hare, quoted in Ander's "Practice of Medicine" (1919) says that out of 520 cases of mediastinal tumours there were only six due to hydatid disease. Verco and Stirling, in Allbutt's "System of Medicine" (1897), say that hydatid disease of the heart "is only found very rarely and only as a pathological curiosity. It has never been diagnosed during life and is not known to have given rise to any symptoms." Graham, in his book on "Hydatid Disease," refers to six cases of echinococcal infection of the heart and says that the diagnosis of the condition is very difficult and that they usually end in sudden death.

All these articles were written before it was possible to examine patients presenting rare thoracic symptoms with the aid of the X-ray screen. I say screen, because I think it is a far greater help to watch the position, pulsations and movements of the contents of the thorax *in situ* than to study a skiagram, although there are doubtless great uses for the latter.

The history of the case is as follows:

W.A.D., a retired farmer, of Wallaroo, South Australia, consulted me on August 20, 1920, for shortness of breath on exertion.

He was a well developed, muscular man, aged 49 years, married, with a young family. He informed me that shortness of breath and swelling of his lower extremities had developed after a recent cold, but on making further inquiries it was elicited that he had been suffering from increasing dyspnoea for the last five years. This had caused him to sell his farm, as his health was becoming too precarious to enable him to attend to his duties.

During this period he had been under the care of numerous medical men and had received many diagnoses and much treatment, but to no avail.

His family history was of no importance, except that one of his sisters-in-law had suffered from hydatid disease.

His past history showed no illnesses liable to produce heart disease and he denied any chance of a tubercular infection.

His colour was a dusky brown; his lower limbs were oedematous as far as the knees. The least exertion caused intense dyspnoea and although he could lie down he felt much more comfortable when propped up in bed. He was of a very cheerful disposition.

On examination, his tongue was clean, digestion and appetite good and his bowels acted daily. His temperature was normal. His pulse-rate was 100 per minute, but the right radial artery appeared a fuller vessel than the left. His blood pressure was 120 mm. systolic, 80 diastolic, with no difference in the two brachials.

The chest was well formed, the cardiac apex beat was neither visible nor palpable on the left side and, at the first examination, no pulsation was detected anywhere in the thorax.

The veins in the left supra-clavicular region stood out prominently, did not pulsate and filled from below when emptied. The veins on the right side of the neck were not visible.

The walls of the chest appeared to move normally.

The vocal fremitus was natural on the right side, exaggerated above the second rib on the left side, but entirely absent below this and far out into the left axilla.

The right side of the chest showed ordinary resonance; but the left side was quite dull from the manubriosternal junction downwards, along the whole length of the sternum, to the lower costal arch, the dulness extending laterally from the second costochondral junction in a curved line with the convexity upwards, out into the left axilla as far as the mid-axillary line and then downwards and inwards to the xiphosternal junction. The percussion note above this dull area was rather hyper-resonant as compared to the right side. The breath sounds on the right side were exaggerated, with no adventitious sounds; on the left side, over the dull area, it was absolutely silent, both as regards breath and cardiac sounds. Above the dull area the breath sounds were coarse, with an increase of vocal resonance.

Posteriorly it was noticed that the left side of the chest, below the scapula, scarcely moved on respiration, the lower half of the chest was markedly dull on percussion, with very feeble breath sounds and a few occasional fine crepitations on deep inspiration. The vocal fremitus and resonance were markedly present over all the dull left base, perhaps rather exaggerated compared to the right side.

No heart sounds were audible on the left side, but an indistinct cardiac apex beat, with first and second sounds, was discernible on the right side of the sternum, below the level of the right nipple. No cardiac bruits were to be heard.

The liver could be distinctly felt below the rib cartilages on the right side, but was not tender on pressure. The urine was normal in quantity; its specific gravity was 1.020 and it contained a trace of albumin, but no sugar. It was acid.

The heart was seen on the fluorescent screen to be pushed over to the right of the sternum and a large, non-pulsatile, rounded opacity was noted in the left side of the thoracic cavity, coming from under the left border of the sternum, about as large as a foetal head at term.

The diagnosis made was that of a hydatid cyst, probably old, with its origin in the mediastinum, compressing the root of the left lung, dislocating the heart into the right side of the thorax and obstructing the left innominate vein.

I asked Dr. H. Gilbert to examine the chest with the screen, without telling him anything about the physical signs; he immediately diagnosed the condition as one of hydatid of the left side of the thorax.

The patient was admitted to a private hospital on September 1, 1920. Dr. Swift saw him on September 2, agreed with my interpretation of the physical signs and sketched the chest on the following day. He recommended the insertion of a needle into the dull area, which was carried out on the morning of September 3, under local anaesthesia, in the presence of Drs. Swift, Gilbert and G. C. Hayward.

The needle of the aspirator was thrust through the third interspace, about two inches (5 cm.) to the left of the middle line of the sternum and appeared to enter a cavity. No fluid came through to the vacuum, but the needle was plugged with a chocolate-coloured, pasty material, which was subjected to a microscopical examination at the laboratory and proved to be made up of broken down blood cells, with much cholesterol, but no other evidences of hydatid.

The patient stood the puncture very well; but the next day the dull area seemed to have a marked pulsation, but no expansion. The left pupil was then seen to be dilated for the first time.

As the patient was evidently going down hill, Dr. de Crespinay was asked to see him with me on September 13. He

confirmed the physical signs and recommended further exploration. Dr. de Crespinay thought there was a pulsation somewhat like an apex beat far out in the left mid-axillary line.

It was decided to explore more thoroughly at 8.45 a.m. on September 15; but at 8.30 a.m. on that day the patient suddenly became very collapsed, with a profuse, cold perspiration, and died at 9.30 a.m.

We were allowed to make a partial *post mortem* examination, which Dr. de Crespinay performed during the day; his report is as follows:

The body was that of a well nourished man, rather cyanosed, with oedematous legs and feet. Examination was limited to the thoracic cavity.

The sternum was adherent to the underlying structures and had to be forcibly separated. When this was done a tough, fibrous cyst wall was found lying anterior to the heart and densely adherent to the thoracic wall. In separating the sternum and sternal ends of the costal cartilages the cyst was ruptured and large quantities of a brown, pasty material exuded. This was scooped out with the hands and amounted to about a litre.

Further exploration showed a large cystic structure, with a fibrous and partly calcareous wall, occupying the lower half of the left side of the thorax. It bulged forwards and inwards almost to the mid-line, dislocating the left portion of the heart backwards, so that only a vertical strip of heart, about 4 cm. in transverse measurement, was contiguous to the anterior chest wall. The cyst appeared to be attached to the apex of the heart and to bulge through the pericardium. It filled the lateral and posterior part of the lower left pleural cavity and was densely adherent to the thoracic cage and to the diaphragm, extending upwards laterally as high as the sixth rib and posteriorly to the sixth or seventh rib, in the line drawn vertically through the angle of the scapula. The left lung was compressed and pushed upwards, sitting, as it were, on the top of the cyst. In removing the thoracic viscera the cyst was torn in several places.

Bulging to the right from the heart, arising from the lower external aspect of the right auricle, was a second spherical cyst about 5 cm. in diameter, with a firm, fibrous wall and containing a putty-like material and numerous small, degenerated daughter cysts. The thoracic viscera were removed *en masse* for dissection and a more detailed examination.

The Left Cyst.—This had its principal point of attachment and apparently its origin in the apical region of the left ventricle. It was attached to the heart in the region of the apex for an area, oval in outline, about 7 cm. in its long vertical diameter by 3 cm. in its antero-posterior diameter. It consisted of two loculi, connected by an oval opening opposite the heart's apex. The anterior loculus, spheroidal in shape, separated the heart from the anterior chest wall and its inner border extended to the mid-line, its upper limit to the second interspace and its lower surface to the diaphragm and its outer surface to the ribs. The fibrous capsule was adherent in all its parts to the surrounding parts and contained numerous calcareous plaques.

The posterior loculus extended backwards and inwards as far as a line drawn vertically through the angle of the scapula; it extended upwards in the same line as high as the level of the spine of the fourth dorsal vertebra. Below it reached to the diaphragm. The posterior portion of the left ventricle was in contact with the chest wall posteriorly and internally to this loculus. The fibrous capsule was beset with calcareous masses and adherent to all surrounding structures.

The pericardium sank into and blended with the fibrous capsule along the line of the junction of the latter structure with the heart. The upper aspect of the capsule was apparently covered with pleura.

On opening the capsule, no remains of hydatids could be found, the contents consisting solely of changed and softened blood clot and gravelly calcareous masses.

No definite communication between either ventricular cavity and that of the cyst could be discovered; but near the apex of the left ventricle the cyst cavity had invaded the myocardium to such a degree that in several places a layer of fibrous tissue, only 1 mm. in thickness, separated the two cavities; owing to the masses of hardened blood clot, it would be easy to overlook a small communication.

The Right Cyst.—This was almost perfectly spherical and

about 7.5 cm. in diameter. It was situated to the right of the heart and was attached to the lower right aspect of the right auricle by a base the size of a florin. Below it was contiguous with and adherent to the diaphragm. Its upper posterior and outer surface was in contact with the base of the right lung. The pericardium and pleura had become incorporated into the fibrous capsule of the cyst. Its contents consisted of a putty-like material and old, obsolescent daughter cysts.

Changes in Adjacent Regions.—The heart had been rotated around all three axes. Its left portion had been pushed backwards, the lower portion tilted backwards and, in addition, the whole heart had been somewhat swung to the right.

The left ventricle was considerably hypertrophied and somewhat dilated; the right ventricle and auricle were both much dilated. The aorta showed little change.

The pulmonary artery was slightly kinked transversely about 1 cm. above its origin. There was no evidence of valvular disease, but both auriculo-ventricular orifices were dilated.

Lungs.—Beyond the impress upon its base made by the right cyst, the right lung showed little change in volume. A slight degree of brown induration was present and two small red infarcts were present on its posterior aspect.

The left lung, however, was extensively affected. Its lower lobe was collapsed and dislocated upwards and its lower surface was adherent to the fibrous capsule of the left cyst. The anterior lower portion of the upper lobe was displaced upwards and compressed, but not collapsed.

Origin of the Cysts.—They apparently sprung either from the sub-pericardial connective tissue or from the heart muscle; the larger cyst was very degenerate, but its cavity definitely invaded the myocardium of the left ventricle. The capsule of the smaller cyst was continuous with the wall of the right auricle.

Remarks.

This case is worth recording, not only on account of its rarity, but also because it demonstrates the great assistance X-rays are in the diagnosis of intra-thoracic lesions.

When you see a rounded, immobile opacity in the thorax, it can only be either a hydatid, a dermoid cyst or a mass of lymphadenomatous glands. If away from the mediastinum it would be unlikely to be glands and nearly all dermoids in the thoracic cavity originate in the mediastinum; effusions, either serous or purulent, even if interlobar, are not rounded. In a lymphadenoma the outline is more lobulated and glands would probably be present in other parts of the body.

The swelling was evidently mediastinal and there was little doubt about its being hydatid; but the difficulty was to decide exactly to which organ it was attached. My own opinion was that it was probably intra-pericardial, as it had so obviously pushed the heart over to the right; but it did not pulsate till after it had been needled and you would expect a cyst connected with the heart to have a transmitted pulsation, although not expansile like an aneurysm. We are still, therefore, obliged to agree with those astute clinical observers, the late Sir Edward Stirling and our last year's President, Sir Joseph Verco, who is still happily with us, in their statement: "Hydatid disease of the heart is only found very rarely and only as a pathological curiosity; it has never been diagnosed during life and is not known to have given rise to any symptoms."

I am sorry we did not have a blood examination, as an eosinophilia would probably have been present to help us to distinguish a hydatid from a lymphadenomatous mass of glands.

It is difficult to understand why, after inserting the aspiratory needle, the dull area became pulsatile and that the left pupil became dilated. The simple operation must have caused some difference in the cyst to account for these changes of signs. It looks as though the contents of the cyst must have become more liquid to account for the pulsation and the irritation of the sympathetic caused the dilated pupil. These two symptoms coming on delayed doing anything in the way of putting in a larger tube and probably saved a catastrophe, as in all probability the further opening would have led to a breaking down of the thin fibrous septum described by Dr. de Crespigny and been attended by a death on the table.

Fortunately for us, death occurred just prior to the hour arranged for the operation.

The *post mortem* examination demonstrated that, even by emptying the large cyst, we should still have left an actively growing cyst on the right side.

I must thank Drs. Swift, Gilbert and G. C. Hayward for their assistance and especially Dr. de Crespigny for making the *post mortem* examination and writing the pathological report.

Reviews.

TROPICAL SANITATION.

"Practical Tropical Sanitation," as the author, Dr. E. P. Minett, Government Medical Officer of Health, British Guiana, states, is a pocket reference book for sanitary inspectors in tropical countries.² The book, however, should have a much wider range of readers, as it provides in a small compass much information of extreme value to residents in the tropics.

The opening chapter on "Keeping Fit," with a few simple hints as to healthy living in warm climates, is especially interesting. Working from 1.30 to 4 p.m. in the tropics is not, as a rule, however, to be commended. The custom of a siesta after the mid-day meal, which is so general in tropical countries, is one which should not be lightly discarded.

The chapters on "Sewage and Refuse Disposal" are excellent and bear the impress of experience gained by the author in Palestine during the war. The illustrations of funnel urinals, incinerators and box latrines are familiar to those who recognized in Egypt what could be done in camp sanitation. The author is a keen advocate for the use of crude petroleum in all latrines, urinals, etc. He gives an excellent formula for an insecticide, which might be used generally in all systems of dry conservancy with advantage in Australia: Liquid soap, paraffin, water. For stock solution, for use as a spray, dilute 1 part to 20 parts.

This useful little handbook will prove invaluable to people living under tropical conditions and can be recommended as replete with information seldom obtainable in such small compass.

Naval and Military.

APPOINTMENTS.

The following announcements have appeared in the *Commonwealth of Australia Gazette*, No. 21 of March 10, No. 24 of March 17, and No. 27 of March 24, 1921:

Australian Imperial Force. Second Military District.

Captain G. R. Hamilton, Australian Army Medical Corps, having resigned, his appointment in the Australian Imperial Force is terminated in England on 30th June, 1920, but to take effect from 3rd October, 1920.

APPOINTMENT TERMINATED.

Lieutenant-Colonel A. J. Mackenzie, 15th April, 1919.

Australian Naval and Military Expeditionary Force.

Honorary Lieutenant-Colonel A. Honman, Australian Army Medical Corps Reserve, is appointed Principal Medical Officer (temporarily), with the temporary rank of Lieutenant-Colonel and with pay and allowances as approved by the Prime Minister's Department, such appointment to take effect from the date of commencing duty.

This announcement is part of the official notification of the appointment of Brigadier-General E. A. Wisdom, C.B., C.M.G., D.S.O., V.D., *Aide de Camp* to His Excellency the Governor General, as Administrator of the Territory of New Guinea and Commander of the Aus-

² Practical Tropical Sanitation: A Pocket Book for Sanitary Inspectors in the Tropics, by E. P. Minett, M.D., D.P.H., etc.; 1920. London: Baillière, Tindall & Cox; Crown 8vo., pp. 130, with 40 figures in the text. Price, 12s. 6d. net.

tralian Naval and Military Expeditionary Force and his staff.

Australian Military Forces.

The undermentioned have been appointed to the Reserve of Officers with substantive rank equivalent to that held by them in the Australian Imperial Forces:

First Military District.

To be Captain—

Percy Allan Earnshaw, 1st January, 1920.

Second Military District.

To be Captains—

Second Lieutenant A. L. McLean, M.C., Reserve of Officers.

Gilbert Charrington Wellisch.

Arthur Braby.

Edward Ventris Bradfield, 1st January, 1921.

Thomas Edward Marshall.

Oswald Jacob Ellis.

Robert Mandeville Alcorn.

William Francis Digges La Touche.

Oliver Latham, 1st October, 1920.

Third Military District.

To be Majors—

Henry Herbert Woppard.

Wilfred Selwyn Kent-Hughes, M.C..

Samuel Charles Fitzpatrick, M.C., 1st January, 1920.

To be Captains—

Leo Luke McMahon.

Joseph Eustace Shelley.

Hugh Compson Trumble, M.C..

James Campbell Nicholson.

William Ivon Hayes.

Stanley Wilson Shields.

Thomas Clive Backhouse.

John Sydney Green.

Jack Garland Skeet, 1st October, 1920.

Nell McColl.

Frank McCallum.

John Ralph Donaldson.

John Ferguson Chambers.

Aloysius Barbata.

John McDonald.

Thomas Muir Hendry.

Fourth Military District.

To be Major—

William James Ellery Phillips, M.C., 1st January, 1921.

To be Captains—

James Gladstone Sweeney.

Arthur Howes Guymer, 1st January, 1920.

Fifth Military District.

To be Majors—

Honorary Major M. Yullie, Australian Army Medical Corps Reserve.

William Sydney Sweet, D.S.O.

James Brook Lewis.

Kenneth Rodas de Vaignes Shaw, 1st January, 1920.

PROMOTIONS, ETC..

First Military District.

Reserve of Officers—

Captain D. A. A. Davis is transferred from the Reserve of Officers, 2nd Military District, 16th February, 1921.

Second Military District.

Australian Army Medical Corps—

Major A. J. Collins, D.S.O., M.C., from the Reserve of Officers, to be appointed Captain, 16th February, 1921.

Captain J. J. Woodburn is transferred to the Reserve of Officers, 16th February, 1921.

Reserve of Officers—

Captain D. A. A. Davis is transferred to the Reserve of Officers, 1st Military District, 16th February, 1921.

Third Military District.

Australian Army Medical Corps—

Captain A. A. McKay to be granted the temporary rank and pay of Major whilst employed at No. 11 Australian General Hospital, 1st January, 1921.

Captain (temporary Major) A. A. McKay is transferred to the Reserve of Officers, 4th February, 1921.

The resignation of Major A. B. Campbell of his commission is accepted, 16th February, 1921.

Reserve of Officers—

Captains J. R. Porter, D. C. Worch, and Honorary

Captain R. D. Lemon to be granted the temporary rank and pay of Major whilst employed at No. 11 Australian General Hospital, 1st January, 1921.

Fourth Military District.

Reserve of Officers—

The resignation of Honorary Captain J. R. Tobin of his commission is accepted, 15th February, 1921.

Fifth Military District.

Reserve of Officers—

The temporary rank of Major granted to Honorary Captain H. J. Gray is terminated, 9th February, 1920.

Sixth Military District.

Australian Army Medical Corps—

Major (Honorary Lieutenant-Colonel) J. A. Newell is transferred to the Reserve of Officers with the rank of Lieutenant-Colonel, 16th February, 1921.

REDUCED FEES AT PRIVATE HOSPITALS.

In *The Medical Journal of Australia* of January 1, 1921, a note was published concerning the arrangements made at certain private hospitals in Victoria for the reception of so-called "intermediate patients" at reduced fees. It appears that advantage is not being taken of the offer of the Private Hospital Employers' Association. The Council of the Victorian Branch of the British Medical Association have arrived at the conclusion that the position is not understood by the members. They have consequently requested us to publish two resolutions bearing on this matter. They are as follows:

(i.) The Victorian Branch of the British Medical Association is prepared to support the movement set on foot by the Private Hospital Employers' Association. With regard to supplying lists to public hospitals, any patient attending at public hospitals should be informed that there are hospitals at intermediate rates, i.e., £3 3s. per week, and that admission to such is on the recommendation of a medical man.

(ii.) That intermediate fees may be charged to patients in intermediate beds set apart in private hospitals or in intermediate hospitals. The reduction of medical fees should be at least 25% of the standard scale of fees. Patients should be admitted only on the recommendation of a medical man.

In the following private hospitals 120 beds have been set aside for this purpose in Melbourne and the suburbs, in addition to a number of beds in private hospitals in the country. Medical practitioners will recognize the advantages which will accrue both to their patients and to themselves if their less affluent patients are informed of this arrangement.

"Allendale," Glenferrie; "Avon," Upper Hawthorn; "Corinella," Williamstown; "Egleton," Malvern; "Edlington," Auburn; "Glenhope," Brunswick Street; "Guildford," Camberwell; "Koonwarra," Armadale; "Lancewood," Kew; "Lister," St. Kilda; "Londa," Elsternwick; "Loughtane," Carlton; "Lumeah," City; "Lynton," Kew; "Marrinook," East Melbourne; "Mount St. Evins," City; "Mt. Wise," Malvern; "Nerrina," Armadale; "Rossmore," South Yarra; "St. Aidans," St. Kilda; "St. Aidans," Moonee Ponds; "St. Andrews," Brighton; "St. Benedict's," Malvern; "St. Helens," Preston; "St. Winifred's," Hawthorn; "Somerset House," City; "Strathearn," Prince's Hill; "Tandarra," East Melbourne; "Trindaford," Moonee Ponds; "Vermador," Glenhuntly. (Incomplete.)

Country.—"Bellaria," Geelong; "Riviera," Geelong; "Cassiford House," Geelong. (Incomplete.)

The Medical Journal of Australia.

SATURDAY, APRIL 9, 1921.

The Naval and Military Medical Services.

On the last day of March the Australian Imperial Force ceased to exist. A chapter unparalleled in the history of Australia has been closed; the memory of deeds of valour, the names that have been written in blood, the living evidence of the maiming effects of modern weapons of war tell us of the great service of yesterday. We have to admit that lurking among our fondest remembrances there is an ineffaceable sadness, born of the fact that much life was lost, that many limbs were sacrificed, that an incalculable amount of incapacity was occasioned as a direct result of defects in the peace-time organization of our medical services. We have clamoured for boldness in the re-organization of these services; the lessons bought at so dear a price should not be forgotten in the moment of reconstruction. The Federal Committee of the British Medical Association in Australia has recently enunciated its views to the Minister for Defence in regard to some of the main principles of a re-organized Army Medical Service. The Minister was asked to lay the scheme before the Federal Committee prior to its final adoption, in order that the representatives of the medical profession might consider all the details and if necessary offer some useful comments. So far this has not been done. It will be conceded by all that the approval of the medical profession is an essential to success in any scheme, for the service must be popular and the conditions of employment of its members attractive. We learn that a new proposal is under consideration and will be submitted to the Federal Committee at its next meeting. In view of the immeasurable importance of the whole subject and of the apparent soundness of these suggestions, the details are explained in this place. They may receive more attention if they are understood by all. It is held that the medical services in time of war exist primarily for the purpose of selecting healthy and physically suitable men for the combatant forces from among those whose services are available and for the purpose of reduc-

ing to a minimum the amount of incapacity during naval, military or aerial operations. This means that the efficient fighting strength of the nation depends more on the medical services than on any other factor. Moreover, it must be conceded that the problem is the same in each of the three branches of the fighting forces. It is therefore proposed that one organization should be formed by which the medical services in the Navy, the Army and the Flying Corps would be provided. In time of peace the strength of the permanent medical service need not be large, but it is of the greatest importance that very many medical officers should undergo training so that they may be equipped for all emergencies. This training must be planned with due regard to the experience of the past. It is useless to ask medical practitioners with experience and training limited to civil practice to meet war emergencies. An elaborate system of post-graduate training, of practical work and of disciplinary preparation is needed, if efficiency is to be attained. Moreover, it is useless to plan an ideal scheme unless it is based on economy. The moulding of the medical services into one organization would increase its efficiency and at the same time diminish the cost of administration.

At present the head of the Australian Army Medical Corp is a military officer whose mouthpiece on the Military Board is a non-medical military officer. The same is true of the Naval Medical Service. The new proposal provides for a Director-General of Medical Services directly responsible to the Minister for Defence. Placed immediately under this responsible officer would be a Director of Army Medical Services, with military rank, a Director of Naval Medical Services, with Naval rank, and a Director of Aerial Medical Services. Associated with these representatives of the three arms of the defence forces of the Commonwealth would be a consulting physician, a consulting surgeon, an expert hygienist and a research worker, skilled in the pathology of tropical as well as other disease. It is further suggested that the advice of a senior Dental Officer and of a senior Matron should also be available.

Under the expert guidance of these experienced officers the facilities provided in the garrison hospitals, in the vessels of the Navy, in the

training camps and in the universities would be utilized to their best advantage to produce part-time and whole-time medical officers competent to perform all that may be required of them in any emergency. The by-word of a service on which Australia can rely, must be "Ever ready!" Patriotism without training, willingness without discipline must be relegated to the past.

While the first requirement of a model service is necessarily good organization, the second point is of scarcely less importance. It is the machinery for keeping the strength of the service up to standard. It is not sufficient to make the service attractive within. Those who stand outside, may be quite innocent of its fascinations. In competent hands the service can be rendered alluring. There may, however, be some difficulty in tempting a sufficiently large number of men to join the service of their free will. It is therefore suggested that the Commonwealth Government be asked to amend the *Defence Act*, so as to provide for the exemption of all undergraduates in medicine from service with the Citizen Forces at the prescribed age and for the compulsory enrolment of every physically fit medical practitioner within one year of graduation in the Defence Medical Service. The period of training would be the same as that prescribed for ordinary service in the Citizen Forces. It would then rest with the administrative heads to make the Medical Services so attractive that a sufficient number of medical officers would be available for all its branches. To those who elect to remain in the Medical Services, there would be ample compensation for any sacrifices they might be called upon to make.

TEAM WORK IN PUBLIC HOSPITALS.

Every large public hospital in Australia has a staff of physicians and surgeons and specialists whose duty and privilege are to minister to the sick—to diagnose disease as quickly as possible and to treat it by rational and effective means. That these staffs include men of good knowledge, experience and ability is the legitimate boast of the noble institutions which claim their services. It is generally conceded that these gentlemen work with enthusiasm and display a very high degree of individual efficiency at their work. The honorary physician of a public hospital

is, with few exceptions, a good physician, the honorary pathologist a good pathologist. In Australia we think largely of the individual and to his particular ability and attainments or the lack of them, we give our approval or disapproval. We do not appraise a man's value as a unit in a diagnostic or therapeutic group, for, except in the field of preventive medicine, team work is more or less unknown. In America largely and in England to a less extent, the grouping of medical men for the diagnosis and treatment of disease in consultation with one another is an established fact, chiefly in hospital, but also in private practice. Perhaps the time is not ripe for the establishment in Australia of medical teams for private practice, but it is becoming more and more apparent that in our public hospitals there is too much individualism and insufficient co-operation between the officers. In former days, before the advent of the radiologist, the pathologist, the bio-chemist and the specialist in the affections of particular organs or groups of organs of the human body, the physician or surgeon in charge of a patient assumed the entire responsibility for the diagnosis and treatment of the disease. Gradually, as certain medical men made a detailed study of some particular branch of medicine or surgery, the clinician found it advisable to claim their assistance. The pathologist, the bio-chemist and the radiologist were asked to carry out investigations of the kind in which they were especially skilled. These investigations completed, the gentlemen concerned were not further consulted and, as a rule, were not encouraged to watch the development of the disease processes in the diagnosis of which they had given valuable assistance. The specialists in diseases of particular organs, on the other hand, soon gained an independence which went to the opposite extreme. The ophthalmic surgeon worked independently of the general surgeon or physician and saw his own patients and carried out his own treatment with rare reference to either of his colleagues. A similar independence was sought successfully by the otologist and rhino-laryngologist. The large hospitals do not claim the services of a urologist, a cardiologist, a gastrologist, a neurologist or a "chest specialist," otherwise it would be interesting to study the attitude of the physician and surgeon. With the appearance of specialists in diseases of every major

organ of the body, the physician would soon find himself filched of the greater part of his time-honoured preserves and the general surgeon would find it difficult to operate without being guilty of trespass! A silent compromise has been effected and certain physicians are said to be relatively more efficient in certain aspects of their study while claiming their devotion to all. Similarly, one surgeon is expert in gastric surgery, another in orthopaedics, yet both deny the limitation of their rights or powers to these respective fields.

From these considerations it may be gathered that we are confronted with the perils of two extremes. Firstly, we may sacrifice unity of diagnosis and treatment to the independence of honorary medical officers, who consider themselves leaders in their individual fields; secondly, by the denial of the rights of consultants in the full meaning of the term to those medical officers who subserve the functions of the more scientific branches of medicine, we may neutralize much of the value of their work and sow in them the seeds of a brooding discontent.

The first danger is exemplified by the position of the rhinologist. He is independent of the physician and surgeon and while his operative skill is generally used to the great advantage of his patients, it occasionally happens that he operates on a patient when a consultation with a non-specialist would have stayed his hand. The rhinologist, for example, is not always in a position to determine that the symptoms of a patient are caused by a septal deflection or spur. Neither is a physician in this position. But both together in consultation are more likely to arrive at a correct conclusion. Similarly a child suffering from undiagnosed early pulmonary tuberculosis is sometimes subjected to the operation of tonsillectomy when consultation with a physician would have relieved the rhinologist of much of his responsibility. It is true that patients are frequently referred by physicians and specialists to one another, but consultations in the true sense of the term rarely occur. When there is any doubt in the mind of either specialist or physician, they should see the patient together and discuss the diagnosis and treatment with one another. With a little organization and the development of a certain amount of team work this arrangement would be practicable. The consultants

would gain in knowledge and the patient would reap the advantages of more skilled diagnosis.

The second extreme is manifested in the position of the radiographer. He is required to report upon skiagrams of the chest taken for the elucidation of the presence of pulmonary tuberculosis. He may issue his report, but receive no information from the physician in attendance as to its substantiation or otherwise by the clinical or pathological findings. As a result the value of his opinion suffers. His reports tend to become mechanical descriptions of the presence of peribronchial markings, mottling and opacities. As a result the physician who carefully examines each skiagram and correlates its appearances with the clinical manifestations, is in a better position to report on the significance of the plate than the radiographer. Similar criticism could be made in regard to opaque meals and enemata in the diagnosis of gastro-intestinal abnormalities.

Until specialists demand and exercise the right of consultation with their more privileged colleagues, their value in the opinions of both practitioners and general public will suffer and they will fail to enjoy the full advantages of their work. Team work is no unpractical dream of the idealist. It is being put into operation more and more in England and America, where even the bio-chemist brings his calorimeter into the hospital ward. We believe that lethargy and not jealousy has delayed the advent of this mutual co-operation in Australia. Let the medical officers concerned take a more intimate interest in each other's work and their experience and utility would be doubled. The community and the profession would welcome the change.

NITROUS OXIDE AND OXYGEN IN OBSTETRICS.

From time to time weighty words of warning are uttered by thoughtful teachers in the medical world against the habit of following fashion in medical practice. We fear that some of those who condemn the habit, sometimes initiate it. It is extremely difficult to distinguish between the adoption of innovations based on sound physiological principles and the following of a fashion. The busy practitioner has little time or inclination to ascertain whether a method of treatment is based on sound, logical premises, on prolonged experience or on the dictum of a reputed authority. If the method becomes popular, notwithstanding the absence of an adequate justification, it may be described as a fashion. It must, however, be admitted that a fashionable mode of treatment may

be beneficial when applied in a proper manner. In view of the necessity of requiring something more than the knowledge that a form of treatment is being adopted by many practitioners, we approach the subject of the induction of nitrous oxide-oxygen analgesia and anaesthesia in obstetrics with caution and a little misgiving. It is largely used in America; in the British Empire the majority of obstetricians have found chloroform safe and easy to apply. The medical profession will not easily forget the amount of charlatany that was associated with the injection of morphine and scopolamine for the purpose of inducing a state of drowsiness and amnesia, unfortunately named "twilight sleep."¹ The National Anaesthesia Research Society of America has recently published a very artistic and attractive monograph in nine chapters and an appendix in which is set forth all the arguments and data available in favour of nitrous oxide-oxygen analgesia for normal child-birth and anaesthesia for obstetric operations.² A great many words are wasted on the subject of the desirability of using some means for removing the suffering of child-birth. No one seriously contends to-day that there is a valid objection to the relief of pain. It is, however, agreed that the relief of suffering may not lessen the efficiency of the uterine contractions nor exclude the aid which the parturient woman is capable of exercising in the expulsion of the child. Very much space is allotted to a discussion of the safety of nitrous oxide-oxygen analgesia and anaesthesia, if properly administered. For those who determine to employ this means of reducing or eliminating suffering in child-birth, we can cordially recommend the chapters devoted to the technique of the administration. The writers are expert and their guidance is safe and explicit. In the next place, the relative toxicity of chloroform and nitrous oxide is important in many respects, but is not a determining factor in the selection of the one or other for this special purpose. It may be admitted that there is some experimental evidence to show that chloroform may produce degenerative changes in the tissues of both mother and foetus. It is claimed by the writers that these changes persist for a considerable time in laboratory animals. Levy has found that chloroform may be the exciting cause of death. British obstetricians claim that when administered with care and skill, chloroform does not cause death in labour. The writers fail to adduce convincing evidence of definite damage to either the mother or her infant produced by chloroform administered with care during the birth. They are in danger of alienating enthusiasm for this method by putting up the bogey of the danger of chloroform anaesthesia in child-birth.

In regard to the ease with which the depth of the analgesia and anaesthesia can be varied when nitrous oxide-oxygen admixture is used, much information is given. There is no doubt that it is advantageous to employ a substance which can yield any desired degree of narcosis from the faintest dis-

orientation up to complete insensibility at a moment's notice. The grave disadvantage to morphine-scopolamine amnesia is that the degree of disturbance cannot be changed, once the dose has been given. The last trace of nitrous oxide is eliminated within a few minutes of the inhalation. Even when chloroform is used it is necessary to administer it in anticipation of each pain and the relief is only complete when the inhalation is continuous. With nitrous oxide-oxygen, the action is so rapid that it can be given intermittently, each fresh pain indicating a renewed inhalation. Some obstetricians claim that it is safe and convenient to allow the patient to apply the mask herself. Objection is raised to this. Another advantage put forward for nitrous oxide-oxygen analgesia is that muscular relaxation is not produced and consequently the progress of the labour is not arrested, neither is the obstetrician impeded in any necessary manipulations. The writers do not mention one very great practical objection to nitrous oxide for ordinary confinement work. The apparatus is cumbersome and difficult to transport. Few practitioners would be willing to carry with them the apparatus and the cylinders or bags of gas to their patient's house or to the private hospital. The apparatus is not usually found in small private hospitals or even in public hospitals in country towns. While we do not claim that a final decision can be given concerning the choice of an analgesic or anaesthetic in obstetrics, we cannot believe that the use of nitrous oxide-oxygen in America is free from fashion. There are many distinct advantages; there are some practical disadvantages. But most important of all, there does not seem to be any real reason to displace chloroform which has theoretical dangers, but which is portable and easily given by a skilled medical practitioner. Perhaps we may learn at a later date whether there is a measurable mortality of chloroform anaesthesia for obstetrical purposes.

BENZYL BENZOATE.

For many years it has been known that opium has a greater efficiency in the relief of pain due to spasm of plain muscle than morphine. In the treatment of intestinal colic, for example, due to contraction of the plain muscle fibres above and below the point of irritation, opium has been found to be a very efficient remedy, while the pure alkaloid as often as not aggravates the condition. Up to a few years ago no rational explanation of this fact was forthcoming. The researches of Dr. David Macht, Lecturer in Pharmacology at the Johns Hopkins University, threw interesting light on the subject. He showed that the alkaloids of opium may be divided into two classes: the pyridin-phenanthrene group, of which morphine is the chief member, and the benzyl-isoquinolin group, of which papaverin is the most important. The first series stimulate the contraction of plain musculature and increase its tonicity, while the papaverin series have an exactly opposite effect, inhibiting the contraction of plain muscle and lessening its tonicity. Moreover, the action of the antispasmodic alkaloids is stronger than that of morphine. This fact furnished a reasonable explanation of the antispasmodic action

¹ The term "twilight sleep" arose as a result of a mistaken translation of the expression "Dämmerschlaf." This term signifies the state between sleeping and waking, a state characterized by drowsiness and confused mental processes.

² Nitrous Oxide-Oxygen Analgesia and Anaesthesia in Normal Labour and Operative Obstetrics, by F. H. McMechan, with the collaboration of a publishing committee. Prepared by the National Anaesthesia Research Society.

of opium. Further investigations tended to prove that the inhibitory action of papaverine was due to the benzyl radical of the molecule. Macht thereupon set out to find a drug free of narcotic properties, non-alkaloidal in nature, yet possessing a benzyl radical capable of reproducing the pharmacological action of papaverin. A well-known commercial ester, benzyl benzoate, used in the manufacture of artificial perfumes, was finally selected as the drug of choice. It was found to be apparently innocuous even when administered in large doses and to be excreted as hippuric acid in the urine, the saliva, the bile and the pancreatic juice. It has one obvious disadvantage, for, being an ester, it is insoluble in water and is pungent and unpleasant to the taste.

Benzyl benzoate, introduced into the selecter circles of therapeutics, achieved a fame never anticipated by its patron. It at once became the drug of fashion in America and was exhibited in the treatment of numerous disease processes. In intestinal colic, gastro-enteritis, pylorospasm, biliary and renal colic, spasm of the urinary bladder, bronchial asthma and many other conditions numerous observers claimed for it and still claim remarkable virtues as an anti-spasmodic. Drs. Hirschfelder and Litterberg, of Minneapolis, wrote warmly of its value in the treatment of dysmenorrhoea. Other workers used it with notable success in the treatment of cardio-vascular conditions associated with a high blood pressure. The systolic and diastolic blood pressures were noted to fall by 10% to 20% after its administration, the action apparently being on the arterial walls. Even *angina pectoris* due to spasm of the coronary vessels was relieved by the use of the drug.

Recently the ester has been used with success in the treatment of many affections of childhood by Dr. John Ruhräh,¹ of Baltimore. Infants and young children are more susceptible than adults to disorders associated with the spasmodic contraction of plain muscle. The drug was first tried in the treatment of pertussis. The results were as good, if not better than, those obtained with atropine, which is a poisonous alkaloid and not suitable as a common therapeutic agent. Dr. Ruhräh used small doses only and he believes that larger doses may have a more potent effect. In the treatment of spasmodic bronchitis and asthma he speaks of benzyl benzoate in terms of admiration. The wheezing and obstructed breathing is rapidly relieved and the child is rendered comfortable and happy. The colic of infants, perhaps the first of all ills to which human flesh is heir, is promptly relieved, as is hiccup when it is sufficiently persistent to need treatment. Pylorospasm not accompanied by hypertrophy of the pylorus is rapidly relieved, the action being remarkably similar to that of atropine.

Even convulsions are favourably influenced by the drug. Dr. Ruhräh mentions the case of a child who had forty to fifty convulsive seizures daily as a consequence of the infection of the wound after circumcision. A few drops of benzyl benzoate in repeated doses rapidly reduced the number of seizures till the boy eventually recovered. We are not informed in what way the drug acts in the relief of convul-

sions and, indeed, there is no proof that the cure was not independent of the therapy. Dr. Ruhräh, however, claims that he has many other cases to prove his contention.

Interest in benzyl benzoate is increasing and it is being mentioned more and more in medical literature. If even a modest proportion of the claims made for it are established, it will prove a welcome addition to the pharmacopœia.

THE PHYSIOLOGY OF STARVATION.

Dr. A. G. Sison, after mature consideration and after having made careful observations on four men who submitted themselves to experimental starvation, has come to the conclusion that more information is needed before a reliable estimate can be made of the part played by inanition and starvation in many diseases characterized by defective metabolism of food.¹ In wasting diseases many of the pathological changes may be due to starvation or to the indirect effects of starvation on the disease processes. He admits that up to the present the chemical pathology of starvation has not been satisfactorily elucidated. He is hopeful, however, that the gaps in our knowledge may be filled in the near future. Dr. Sison finds that protein catabolism is stimulated in the early stages of fasting. Later the elimination of the products of protein catabolism reach a constant level. It has been suggested by Voit that in the early days of a fast the circulating protein is used up at an increased rate. When the tissues are destroyed for the purpose of rendering the so-called morphotic protein available, the excretion of nitrogen tends to decrease. Still later, when recovery is excluded, the excretion of nitrogen again increases. He observed that loss of weight begins early and is continuous. It is accompanied by a loss of the subcutaneous fat, especially of the face and abdomen. The normal relations of the abdominal and thoracic viscera undergo change. The lungs become hyper-resonant, owing to a considerable loss of water. The heart is diminished in outline. He is inclined to attribute this apparent change to the encroachment of the resonant area of the lungs. At the same time there is evidence of a distinct diminution of the size of the organ. The blood pressure becomes lowered, the pulse beat slow and the pulse volume large. The number of red blood cells is slightly and that of the leucocytes considerably diminished. The upper border of the liver dulness is depressed and the lower border raised. The spleen is also diminished in size. The breath has the odour of acetone. Benedict who has studied the metabolism in fasting men and animals, has pointed out that fat is incompletely oxidized and that the intermediate products, the acetone bodies, are excreted. It will be admitted that Dr. Sison is justified in his complaint that too little attention has hitherto been given to the physiology of starvation. Since there are no means of studying the effects of a deprivation of food in the course of wasting diseases, as distinguished from the disease process itself, this subject should be taken into consideration by physicians and physiologists.

¹ American Journal of the Medical Sciences, January, 1921.

² The Philippine Journal of Science, October, 1920.

Abstracts from Current Medical Literature.

MEDICINE.

(132) Dengue.

M. D. Levy gives some observations on an epidemic of dengue in Galveston (U.S.A.) during August to November, 1918 (*Medical Record*, June 19, 1920). It is estimated that between 4,000 and 6,000 persons (approximately one out of every six) were affected. It is possible that the infection was introduced into Galveston by some marines from the West Indies, where dengue is known to be epidemic. At irregular intervals Galveston has experienced mild epidemics of dengue, such as those of 1897 and 1908. Dengue is definitely mosquito-borne. Formerly *Culex fatigans* was supposed to be the only variety responsible for its transmission. Recent work, however, tends to incriminate *Stegomyia calopus*. Both are present in Galveston in abundance during the summer months. Graham, in 1903, stated that he found a protozoal organism in the blood of patients ill with dengue, which he considered responsible for the disease. His results have not been confirmed. McMullin has suggested that a poisonous protein is injected by the bite of a mosquito and subsequently another mosquito biting the same individual injects more of the protein; an anaphylactic reaction results, which exhibits itself as dengue. In the epidemic recorded, a noticeable feature was the marked irregularity and variability of the symptoms. The onset was abrupt, being ushered in with a sudden rise of temperature and headache. The temperature, with few exceptions, was only moderately elevated. The "saddle-back" temperature curve was observed in a large majority of the cases. The pulse was slow in proportion to the fever. In no instance was the Faget type of pulse observed. The pains were not severe. Eye pains, with headache, were most frequent, general body pains coming next. The eye pains were purely of a muscular nature, being caused by the movements of the eye-ball. The body pains were located chiefly in the lumbar region. In not a single instance were the swollen joints, mentioned by Ostler, noticed. Nervous symptoms were very prominent, chiefly exhibited as a marked depression, lassitude, irritability or insomnia. In one case well marked hallucinations were present. The skin eruptions were extremely varied, ranging from a large, well marked morbilliform type to an almost imperceptible scarlatiniform eruption. A preliminary erythema was noted in the majority of cases. With the terminal rise of temperature the typical rash appeared. Definite glandular enlargements were not uncommon, the inguinal, axillary and posterior cervical groups being involved in that sequence. As regards the blood picture in dengue, the characteristic changes are a more or less marked leucopenia, with a reduction in the polymorpho-nuclear cells and

eosinophile cells and a relative increase in lymphocytes. Bonne, in a dengue-like fever in Dutch Guiana, found polychromatophilia, with some basophilic degeneration of the red cells. In some of the author's cases, in addition to the usual leucopenia, there was well marked reduction of the red blood cells, with a greater proportionate reduction of the haemoglobin, giving a picture of secondary anaemia. As a rule, one attack of dengue is supposed to confer immunity, at least in so far as reinfection during the same epidemic is concerned. Repeated attacks, however, have been observed during the same epidemic. The diagnosis of dengue is usually simple, especially during an epidemic. The differentiation from influenza may present a very nice question. In some instances influenza may show a rash which might be confused with that occurring in dengue. Scarlet fever is differentiated by the leucocytosis; morbili by Koplik's spots, coryza and respiratory affection; acute rheumatic fever by the leucocytosis, acid sweating and joint affection. Yellow fever is not likely to be seen, but when present might be extremely difficult to differentiate. The jaundice, albuminuria, Faget type of pulse and absence of marked blood changes would serve to differentiate between yellow fever and dengue.

(133) Gaucher's Disease.

S. W. Sappington observes that, according to Mandlebaum, up to 1916 there were 19 instances of Gaucher's disease in the literature in which the diagnosis had been determined by histological examination. Since then other cases reported brought the total up to 24, to which the author adds another (*Journ. Amer. Med. Assoc.*, July 10, 1920). The patient, aged 50, a Polish Jew, a shoemaker, though somewhat "queer," was apparently in good health and attended to his business regularly. On the day of his death he acted eccentrically, struck at one of his customers and chased her from the shop. So violent were his actions that he was shot by a policeman and died in hospital. At the necropsy, apart from the results of the bullet wounds, the liver exhibited what looked like a chronic hepatitis. The retro-peritoneal glands were moderately enlarged. The spleen weighed 825 grm. and measured 23 by 12.7 by 5 cm.. The organ in general was quite soft, in some spots almost mushy; but scattered throughout were firm nodules, more apparent to the finger than to the eye. These nodules had a consistency similar to that of secondary tumours in malignant growth of the lung. On section the firmer areas were not plainly discernible. The general colour of the sectioned spleen was normal, but closer inspection revealed that the nodules were of a deeper brownish-red than the surrounding parts. The firmer masses were from 0.5 to 1.5 cm. in diameter. Microscopical examination showed rather marked thickening of the arteries and an abundance of pigment. The nodular portions of the spleen corresponded to those areas in which the dilated sinuses were prominent. F. S. Mandlebaum re-

ported that sections of the spleen showed the typical lesions of Gaucher's disease. The dilated sinuses, the arrangement of the large cells, with the peculiar type of cytoplasm and small nuclei, often multiple, and the pigment, are characteristic features. Those portions of the spleen in which the sinuses were not prominent appeared to be devoid of large cells, but, with the high power, the cells were seen among the pulp cells. The patient was the oldest victim of Gaucher's disease on record. As the disease is supposed to begin in infancy or early life and last many years, it might be expected that the older the patient the greater would be the size of the spleen. In one case the spleen weighed 8,100 grm. and in another 4,990 grm.. In the author's case, the spleen was the smallest of the Gaucher type occurring in adults, indicating that the disease began late in life or was extremely slow in development. The familial aspect of this disease has been emphasized and the author is of opinion that it is more common in Jews. Anitschkow demonstrated large cells containing lipoids in animals experimentally fed on fats and lipoids. In these cases the lesions resembled those of Gaucher's disease so closely that Aschoff referred to the condition as "pseudo-Gaucher." Mandlebaum and Downey believe that in genuine Gaucher's disease, fat or lipoid bodies cannot be demonstrated in the large cells by micro-chemical means. The peculiar substance in the cells is in all probability of complex proteid nature in combination with lipoids. Cases of diabetes have been reported with lipoidæmia. The resemblance to Gaucher's disease in these cases has been noted.

(134) The Mendelianism of Migraine.

The hereditary character of migraine has usually been accepted by writers on this affection. J. A. Buchanan (*Medical Record*, November, 1920) has investigated the incidence of this condition from a study of 1,300 persons who suffered from migraine, treated at the Mayo Clinic during 1919. For the purposes of this investigation, the term migraine denotes an affection characterized by paroxysmal attacks of pain, usually in the head, either unilateral or bilateral, but occurring also in the abdomen, associated with nausea and vomiting, together with mental depression, visual derangement and many vague, somatic disturbances. As a result of his investigations, the author concludes that migraine is a distinct type of disease and that its incidence in families is an expression of the Mendelian phenomenon. It is, moreover, a definite part of the economy of the individual and has no harmful influence on longevity.

NEUROLOGY.

(135) Aphasia and Kindred Disorders of Speech.

Henry Head (*Brain*, Vol. XLIII., Part 2) writes a description of aphasia and kindred disorders of speech based

mainly on the investigation of young men suffering from gun shot wounds of the head. He employed certain new serial methods of examination and is of opinion that disorders in the use of language, due to a unilateral lesion of the brain, cannot be classed under the categories of isolated affections of speaking, reading or writing, nor can they be explained as due to destruction of images, "visual," "auditory" or "motor." On the other hand, "word blindness," "mind blindness" and what Jackson called "imperception" are all associated with more or less disturbance of the power to form images. The "motor" aspect of these disorders of language is not solely an "anarthria" or high-grade articulatory defect, as held by Pierre Marie. In cases of so-called "motor" aphasia not only external speech but certain aspects of internal verbalization are affected. There is loss of the power to formulate words, proved not only in speech but in writing and spelling. Head groups the affected functions under the heading of "symbolic thinking and expression," because the gravest and most definite disturbance is to be found in the use of words, figures and other symbols. But this heading does not exactly define the extent of the loss of function. Not only may the patient fail to speak, read and write perfectly, but he may be unable to plan the relative position of objects with which he is familiar, e.g., the furniture in a bedroom, although he can indicate the site of each one of them individually. He mistakes the significance of the two hands of a clock. He fails to comprehend the full meaning of a picture, although he may recognize the details. Any act is liable to suffer which requires the perfect antecedent formulation of the ultimate intention towards which it is directed. The more nearly a symbolic action approximates to a proposition, the greater the difficulty it will present. Next it is shown that there are various dissociated forms of symbolic thinking and expression. (i.) Verbal aphasia: This is essentially a defect of word formation. Words are evoked with difficulty, slowly and haltingly. Writing and spelling are very defective. Patients with this condition recognize their faults, however, and can draw, play cards and comprehend jokes set out in print or in pictures. (ii.) Nominal aphasia: This is essentially a defective use of names and want of comprehension of the nominal value of words or other symbols. Reading and writing are extremely difficult and while the patients are unable to play cards, they may be able to play chess and draughts. (iii.) Syntactical aphasia: The patient tends to talk jargon. (iv.) Semantic aphasia: This is a want of recognition of the full significance of words and phrases. The patient may understand each word or short phrase and take in the details of a picture, but the ultimate meaning escapes him. He cannot play games and jokes set out in print or pictures are rarely apprehended in their full significance. In conclusion the paper deals with the clinical pheno-

mena of loss of speech from the physiological point of view, while the anatomical is not considered.

(136) Epilepsy.

In the *New York Medical Journal*, December 4, 1920, appears a series of articles dealing with epilepsy from various standpoints. Smith Ely Jelliffe, under the title of "The Parathyroid and Convulsive States," on the ground that certain conditions of "hair trigger" synaptic activity, illustrated by tetany, may be benefited by parathyroid medication, suggests the same treatment in certain cases of epilepsy. He advises administration by way of the rectum. William T. Shanahan, Medical Superintendent of the Craig Colony for Epileptics, urges a campaign to provide more colony care and proper supervision for epileptics. New York abounds in patients calling for such treatment; money alone is wanting. Chester A. Marsh, writing on epilepsy from the comparative aspect, thinks that the phenomena are an abnormal muscular expression of strong mental states. The reaction is seen in an individual who, possessing a poverty of interests in his environment and entertaining conflicting thoughts which have the effect of weakening his mental state, cannot escape from strong emotional feeling as does the normal man. Walker H. Kidder, on the subject of "Mentality in Epilepsy," points out that there is a basic mental condition essential to the development of epilepsy and that whatever influence tends to better that condition must in great measure help in combating the general epileptic state. For prognosis it is safe to base predictions on the mental state. Harvey M. Watson reports twenty-two cases of epilepsy treated with luminal and while admitting its usefulness, says it has all the bad effects of bromide with the exception of the rash. It should be used over a long period and continuously, as once its administration is discontinued the epileptic habit returns with increased severity. E. E. Uniker, writing on the training treatment of epileptics, declares that from the very beginning efforts should be centred on imparting to the patient in the most acceptable form a thorough knowledge of his disease and the methods by which he is to secure an arrest or cure; that the training treatment seems the best method of re-educating the epileptic, but that it requires great patience and much time to accomplish even a little. If, however, the fight is carried on tactfully the results are always gratifying and never fail once the patient begins to act of his own accord.

(137) Some Factors in Psychotherapy.

William Brown (*Journ. of Neurol. and Psychopath.*, August, 1920) points out that there is no panacea for the treatment of the psychoneuroses. Different schools of thought may emphasize one or other factor of cure, but there can be little doubt that these factors are many and a rational psychotherapy should take account of all.

In his opinion, hypnotism and suggestion do not coincide. All men are more or less susceptible to suggestion, but hypnotism is something more definite than this. It is a "second state," corresponding to the condition of the hysterical. One can artificially increase the suggestibility of most normal people by appropriate means and this is not *co ipso* hypnosis. The writer emphasizes the factor of suggestion as a *vera causa* in psychotherapy. In the case, especially, of bad habits, such as enuresis and masturbation in children, analysis and persuasion often fail where repeated suggestion produces a complete cure. In his method, he asks the patient to relax his muscles as completely as possible while lying on a comfortable couch and to think of sleep and he continues this treatment for an hour at a time, giving appropriate suggestions every ten minutes. Every case of enuresis he has treated by this method has cleared up completely. In selected cases suggestion is all that is needed for complete and permanent cure. It is, of course, assumed that a thorough neurological and psychological investigation is first carried out. Freudian adherents find a difficulty here, because of their identification of suggestion with transference. The training of children into good habits, even in the first few days after birth, illustrates the enormous potency of suggestion and its relative independence of transference.

(138) The Anxiety Neurosis.

E. H. Laverson (*Medical Record*, December 4, 1920) gives a general description of this neurosis, the nuclear symptom of which is anxious expectation. It must be distinguished from neurasthenia. The clinical features include general irritability and hypersensitivity, often causing insomnia and anxious expectation of many kinds. On trivial grounds the patient repeatedly dreads the onset of some serious affection or event. The anxiety may break through into consciousness suddenly and induce attacks of varying nature—heart attacks, nervous dyspnoea, sweating, tremor, vertigo, digestive and vasomotor disturbances and parästhesias. All these result from a state of chronic anxiety. In women there is the sexual anxiety of virgins, of the newly married, of those wives whose husbands practise *cotitus interruptus* and of women at the climacteric. Similarly, of men those suffer who practise *cotitus interruptus* and whose potency is diminished with the advancing years. In both sexes masturbation and exhausting exertion, such as night watching and nursing the sick, are causes. The writer favours Freud's views on the sexual aetiology of the condition and holds that even in those cases in which the illness is caused by over-exertion, it is still established on the foundation of a sexual mechanism, since general exhaustion renders the mind unable to care for the somatic excitement which continually makes demands on it.

British Medical Association News.

MEDICO-POLITICAL.

A special general meeting of the Queensland Branch was held at the B.M.A. Rooms, Adelaide Street, Brisbane, on March 18, 1921, to consider the report of the sub-committee appointed to confer with representatives of the friendly societies. The chair was taken by the President, Dr. A. Graham Butler.

The minutes of a special general meeting held on January 21, 1921, were read (see *The Medical Journal of Australia*, February 19, 1921, page 163).

The President reported to the members that the representatives of the Branch, namely, himself as President, Dr. A. Anderson, Dr. A. B. Carvosso, Dr. A. C. Ward, Dr. L. P. Winterbotham and Dr. R. Marshall Allan, had met Messrs. Spink, Morgan, Eaton, McLachlan and Hoskins, representing the friendly societies in Queensland, on February 23, 1921. At that conference the seven resolutions adopted by the Branch on January 21, 1921, had been discussed. The representatives of the friendly societies had claimed that the increase in the lodge fees to 26s. per member would represent the necessity of collecting an additional 6s. *per annum* from their members. The societies had no accumulated funds and were almost insolvent. Moreover, the societies received no subsidy from the State. It had further been stated that the average lodge member had not benefited by the effect of the wages awards and that owing to the high cost of living and the irregularity of work, his position was no better than it had been in 1915. In one society with 9,000 members, 580 were "unfinancial." The argument had been used that not more than 50% of lodge members on the doctors' lists required medical attention. The cost of management had increased by 75%. In these circumstances the friendly society delegates had suggested that the increased rates should be fixed at 22s. 6d. The representatives of the Branch had put forward the argument that they were asking for an increase of 30%, which compared favourably with the 75% increase in the lodge expenses. The delegates of the friendly societies had considered that the doctors were in a better position to bear the increase than were the members of the working classes. As a result of this discussion the majority of the members of the sub-committee recommended the acceptance of the proposal that the lodge rates be fixed at 22s. 6d. with the proviso that the matter be reconsidered at the end of three years. Two other recommendations had been put forward by minorities of the sub-committee. The first was that the amount demanded be 24s. and the second that it be 26s.

Dr. J. A. Cameron explained the manner in which they had obtained an increase to 30s. from the lodges in Ipswich. He strongly advocated that the original resolution should not be altered.

Dr. A. B. Brockway moved and Dr. L. P. Winterbotham seconded:

That the rates be 24s.

An amendment was moved by Dr. C. E. Tucker, seconded by Dr. A. C. Ward:

That the rate be 26s.

The amendment was put to the meeting and was lost on the casting vote of the President. Dr. Brockway's motion was then put to the meeting and was carried unanimously.

As a result of further discussion it was decided that no limit of time should be required for the application of this provision.

The President reported that the representatives of the friendly societies had urged the sub-committee to alter the demand for an increased rate for single female members from 15s. to 12s. 6d..

On the motion of Dr. A. B. Carvosso, seconded by Dr. A. C. Ward, it was resolved that the offer of 12s. 6d. be accepted.

The President reported that the delegates of the friendly societies had agreed to the increase of the confinement fee to £3 3s..

In regard to the question of mileage the friendly societies were prepared to accept the proposals of the Branch, namely:

That the maximum be a three mile limit for members in the cities of Brisbane and South Brisbane and

two miles for members in suburban areas by road from the doctor's residence.

The President pointed out that the friendly society delegates had asked for the deletion of the second paragraph of the original resolution according to which a differentiation was made between old and new lodge members. It was moved by Dr. A. B. Carvosso and seconded by Dr. A. B. Brockway that this paragraph be deleted. The paragraph was accordingly deleted.

In the next place the President dealt with the income limit clause. The resolution of the Branch passed on January 21, 1921, was as follows:

That the maximum salary of a bachelor when joining a lodge be £260 and of a married man £365 and that they cease to enjoy the medical benefits of the lodge when as a bachelor he receives £312 or as a married man £416 *per annum*.

The delegates of the friendly societies had expressed their unwillingness to accept an income limit clause of any description. They had argued that a member usually joined a lodge at an early age when he was earning a small wage, such as £100 a year. As his salary increased, his expenses became greater. It was contended that it would be unfair to deprive the lodge member of the right to obtain his medical attendance through the lodge to which he had contributed during a series of years. The delegates had also pointed out that very few persons in affluent circumstances claimed treatment from lodge surgeons under the agreement. The medical delegates had asked the representatives of the friendly societies to state what they considered a reasonable income limit for bachelors without dependants and for married men on joining the lodges. They had also been asked to name the annual income which in their opinion should disqualify lodge members for the medical benefit. Mr. Morgan had replied that this matter could not be decided until the members had been consulted at their quarterly meetings in June.

The sub-committee had put forward the recommendation that the resolution quoted above be deleted and that one of the following paragraphs be substituted in its stead:

(a) Any person joining a lodge after January 1, 1921, shall be ineligible for medical attendance who is in receipt of an income exceeding £500 *per annum*; or

(b) The maximum salary of a bachelor without dependants when joining a lodge for medical attendance shall be £260 and of a member with dependants £365 *per annum*.

Dr. A. B. Carvosso moved and Dr. A. G. Anderson seconded that paragraph (a) be accepted.

Dr. D. G. Croll moved as an amendment and Dr. C. E. Tucker seconded, that paragraph (a) be accepted with the substitution of £400 for £500.

The amendment was lost. Dr. Carvosso's motion was carried by a majority of one.

The President reported that the delegates of the friendly societies had signified their approval of the resolution concerning the use of uniform certificates.

On the recommendation of the sub-committee the date on which the agreement would come into force was altered from April 1, 1921, to July 1, 1921.

Dr. A. B. Brockway moved and Dr. A. B. Carvosso seconded the following, which was adopted:

That the Council be requested in carrying out the proposal of the special meeting to treat these resolutions as final.

Dr. D. G. Croll asked whether they were in order in altering the wage limit which would mean an amendment of a fixed clause in the Model Lodge Agreement.

The President drew attention to the wording of the second proviso of the Model Lodge Agreement. It was as follows:

If the medical men taking lodges in any town or district shall agree together that the wage limit contained in this agreement is unsuited to such town or district they may submit to the Council of the Branch proposals which they consider suitable to that town or district and if the Council of the Branch approve may make agreement with their lodges on the approved terms.

It was therefore competent for the Council to alter the terms of the income limit clause.

Dr. C. E. Tucker, on a point of order, questioned whether

the meeting could alter the resolutions of the meeting of January 21, 1921. As no notice of motion had been given, he contended that the meeting had no power to rescind or alter the previous resolutions.

A discussion ensued. Dr. Espie Dods gave notice of motion to the following effect:

That at the next meeting of the Branch the resolutions passed at the special meeting of January 1, 1921, be rescinded and that the resolutions passed at the special meeting of March 18, 1921, be adopted with the exclusion of the clause relating to the wage limit.

William Hilliar Long, Esq., M.B., B.S., 1920 (Univ. Melb.), of Geelong Hospital, has been elected as a member of the Victorian Branch.

Leslie John Scott, Esq., M.B., Ch.M., 1920 (Univ. Sydney), of The Hospital, Rydalmerle, has been nominated for election as a member of the New South Wales Branch.

Medical Societies.

THE MEDICAL SOCIETY OF THE CHILDREN'S HOSPITAL, BRISBANE.

A meeting of the Medical Society of the Children's Hospital was held at the Hospital for Sick Children, Brisbane, on February 25, 1921, Dr. G. P. Dixon, the President, in the chair.

Dr. J. J. Power exhibited a series of patients to illustrate several varieties of fracture in the neighbourhood of the elbow joint. The first patient had suffered a fracture of the lower end of the humerus involving the elbow joint. There had been very little displacement of the fragments. The limb had been put up in a position of acute flexion for 14 days. It had then been freed and active movement had been instituted. The movements were almost complete and the bone was seen in the skiagram to be in good position.

The second patient had had a fracture into the elbow joint with separation of the trochlear and epitrochlear surfaces and dislocation outwards of the radius and ulna. The internal condyle had also been separated. The limb had not been attended to for a week. It had been placed in a position of acute flexion and maintained in this position for three weeks. Dr. Power pointed out that extension from the position of flexion to the right angle position could be effected. Under the influence of exercise, gravity and weight carrying, a good final result was anticipated.

In the third case there had been separation of the epiphysis of the radius. The treatment had consisted in placing the limb in a position of acute flexion for one week and then instituting active movement.

Dr. Power discussed the importance of placing the arm in a position of extreme flexion after fracture involving the bones near the elbow joint. He sought expressions of opinion concerning the treatment of fractures of both bones of the forearm. In France they had adopted the expedient of placing the limb in a position of full supination under guidance of X-ray pictures. This method gave the greatest interosseous interval, a matter of great importance in the treatment of comminuted gun shot fractures.

Dr. N. G. Sutton referred to the teaching of Sir Robert Jones, that the determining factor in these cases was the site of the fracture in relation to the insertion of the *pronator radii teres*. In the position of full supination there was a danger of rotary displacement, which would make full pronation impossible. He therefore considered that the best position in these cases was the mid-prone position.

Dr. R. H. La Barte Cummins spoke of the discomfort experienced by the patient when the limb was held in the position of full supination. He preferred the mid-prone position. He expressed the opinion that the position of full flexion was not without danger in the treatment of fractures near the elbow joint. He has seen paralysis and Volkmann's contracture follow the prolonged employment of this treatment. No limit of time could be fixed for this treatment. The patients had to be watched from day to day.

Dr. G. P. Dixon agreed with Dr. Sutton concerning the importance of the position of the fracture in relation to the insertion of the *pronator radii teres*. In many cases full supination was undoubtedly the best position. If it

were possible, the fracture should be reduced under X-ray control.

Dr. J. L. Selwood described the method of treatment employed in the Hospital for Sick Children. The limb was put up in a position of acute flexion until the third day. Passive movements were then employed associated with active movements on the fifth day. "Complete success" was obtained usually in four weeks and always in six weeks. He referred to the exceptional occurrence of ankylosis as a result of the treatment. In these cases extension was applied with the patient under the influence of an anaesthetic. The adhesions were broken down and the limb was then placed in the position of acute flexion. The results were good, but the restoration was much slower than in uncomplicated cases.

Dr. S. F. McDonald quoted Mr. Hamilton Russell's opinion condemning passive movement. When passive movement was used, the muscles were held "on guard" and acted as fulcra, the point of application of power being the fractured ends of the bone. In active movement every muscular contraction was accompanied by a relaxation of the opponents. There was consequently no lever action exercised.

Dr. J. L. Selwood did not agree with this view. He asked how active movement could be applied in the case of an infant.

Dr. S. F. McDonald presented a baby, aged five months, the subject of a congenital heart defect. The child had been born at full term; the labour had been normal. It was being fed at the breast. The child weighed 6.35 kilograms. It had had *talipes* of the right foot. This condition had been much improved under treatment by Dr. A. V. Meehan. There was well-marked cyanosis. A systolic murmur and a systolic thrill were felt over the whole of the precordial area. Dr. McDonald offered the probable diagnosis of patent septum and pulmonary stenosis. He asked the members to express their views concerning the prognosis.

Dr. J. Lockhart Gibson thought that the thrill often denoted a valvular lesion rather than patency of the septum.

Dr. D. A. Cameron stated that he had not seen a patient with a congenital cardiac defect survive beyond the 18th year.

Dr. A. H. Marks recalled the case of a boy of 12 years who was very strong and healthy. The blue-black colour of his face could be detected at a distance of 100 metres.

Dr. C. A. Thelander held that marked cyanosis was a very bad sign.

Dr. A. C. F. Halford spoke of a "blue boy" with signs similar to those of the baby. He was at the time 15 years of age. He was attacked by rheumatic fever, but had recovered well. In fact, Dr. Halford said he seemed the better for it. At the age of 24 years he was leading a vigorous and active life, though he was still very blue.

Dr. E. S. Meyers recited the chief details of the case of a baby aged three months who had been subject to attacks of screaming. There had been no cyanosis, but definite pallor. No murmur had been heard. The baby died suddenly. At the autopsy a patent ventricular septum was discovered. There were also recent vegetations on the mitral valve. The condition had been diagnosed during life as a congenital heart disease, atelectasis or persistent thymus.

Dr. Meyers then asked the members for an expression of opinion concerning the advisability of operating for very enlarged tonsils in two children with congenital heart disease and acquired heart disease.

Dr. J. Lockhart Gibson thought that the tonsils should be removed, though he recognized that there would be a definite element of danger. The risk should be taken if there were a good prospect of ultimate survival.

Dr. A. Anderson considered screaming to be a puzzling symptom. It was, however, not uncommon. Morphine was the only effective remedy.

Dr. McDonald's second patient was a girl aged 15 years, with muscular dystrophy. The child had been able to walk at the age of 18 months when placed on her feet, but had not been able to rise from the floor until the age two years. The signs were weakness mainly of the quadriceps and to a less extent of the scapular muscles, marked scoliosis and some affection of the face. All the reflexes were present but sluggish. All the muscles reacted to faradism; there was definite reaction of degeneration.

Dr. D. A. Cameron pointed out that the muscles were

hard and not distinctly atrophic. He raised the question whether the condition were not pseudo-hypertrophic paralysis in a late stage.

Dr. C. A. Thelander did not think that the muscles were of typical shape.

Dr. Power suggested that re-education and exercise might yield satisfactory results.

Dr. J. L. Selwood referred to a case of unilateral muscular dystrophy he had seen in a school child.

Dr. McDonald, in reply, stated that the distribution of the signs suggested the third, miscellaneous type as opposed to the typical juvenile type of Erb. The age of the patient was also against this diagnosis, as well as that of the facio-scapulo-humeral type. On the other hand, the pseudo-hypertrophic form rarely occurred in girls. Dr. McDonald pointed out that one brother of the patient had died in infancy after having exhibited similar symptoms. In the differential diagnosis the electrical reactions excluded progressive muscular atrophy of the Charcot-Marie-Tooth type. There was no actual paralysis, only weakness of the muscles.

Dr. McDonald's third patient was a boy aged 9 years with congenital syphilis. Two other members of the family showed manifestations of syphilis. When the patient was two years of age he had a fall on the back of his head. Right-sided hemiplegia followed. Moderately free movements of the right leg had returned, but there were still atrophy and drop-wrist deformity of the right arm. He suffered from epileptic attacks with gustatory aura confined to the right side.

Dr. J. Lockhart Gibson referred to the fact that he had treated the boy and his sister for interstitial keratitis.

Dr. D. A. Cameron suggested that the condition had arisen as a result of physical trauma leading to haemorrhage from an already weakened artery.

Dr. A. C. F. Halford drew attention to the normal speech. He assumed that the speech centre on the right side must have been developed.

Further discussion ensued concerning the treatment adopted in cases of congenital syphilis.

Dr. J. Lockhart Gibson exhibited a patient who had suffered from severe "cerebral plumbism." The boy was six years of age. He had first been seen in the out-patient's department in August, 1920. He then complained of headache. The ophthalmic surgeon had discovered two or three diopters of papilloedema, but no squint. The blood serum had been submitted for the Wassermann test, but no reaction had been obtained. The symptoms disappeared while he was under treatment. The lad had returned in November with a renewed complaint of headache. There was then no papilloedema and no basophilia. In February, he suffered from headache and vomiting. There was at that time no paralysis of the recti muscles. Two or three diopters of papilloedema and basophilia were discovered. Increased cerebro-spinal fluid pressure was diagnosed on the escape of 8 to 12 c.c.m. of fluid. Dr. Gibson stated that the patient had "done very well since." He remarked on the difficulty of diagnosis in cases of lead poisoning with mild symptoms. He regarded the presence of basophilia as an easier sign to elicit than lead in the urine or on the de-ionizing plate.

Dr. C. A. Thelander asked Dr. Gibson how lead was detected on the de-ionizing plate. He spoke of a child with headache and vomiting. The symptoms had been attributed to cyclical vomiting as the only alternative to lead. There was no papilloedema, but a paralysis of the external rectus. Later foot drop had appeared.

Dr. Lockhart Gibson stated that the actual detection of lead on the plate offered no difficulty. He admitted that contamination was likely to occur.

Dr. J. L. Selwood said that he had seen much lead poisoning in school children. The symptoms were usually of a negative character. The children were backward and exhibited a lack of development. There was often a blue line on the gum adjoining the first molars, not the incisors. This was frequently associated with a great deal of tartar. Dentists had informed him that only lead could produce this blue line.

Dr. A. C. F. Halford held that in all these obscure cases, the possibility of lead should be remembered. He cited instances in which lead poisoning had been overlooked. He

thought that the amount of lead poisoning in Brisbane was often not recognized. Many attacks called bilious were in reality due to lead. He suggested that it might be worth while calling the attention of the International Health Board to the question of lead poisoning, in order to have a campaign initiated as had been done in connexion with hookworm.

Dr. Gibson said that this would be unnecessary. To stop lead poisoning in children it was necessary for the Department of Public Health to forbid the use of lead in any place within the reach of children.

Dr. E. S. Meyers dealt with the pitfalls in the detection of the blue line. He held the opinion that many cases were diagnosed as instances of lead poisoning on inadequate grounds.

Dr. N. G. Sutton showed a boy aged six years with congenital elevation of the shoulder. The case differed somewhat from the usual type of Sprengel's shoulder. The shoulder was quite free, but the scapula movements were limited by fibrous union between the vertebral angle of the scapula and the first dorsal vertebra. There was slight scoliosis and wry neck. He had desired to operate, but the parents had withheld their consent.

Dr. Thelander stated that he had delivered the mother of Dr. Sutton's patient. The condition had not altered, except that the wry neck had been more marked and a definite laryngospasm.

Dr. D. A. Cameron showed three patients with hare lip. One was a child of two years on whom an operation had been performed with success, notwithstanding the great deformity present. The two others were very young. He proposed to operate on them when they reached five months.

Dr. G. P. Dixon exhibited a patient in whom he had applied a bone graft to cover a nasal defect. The patient was a girl aged 15 years with a congenital syphilitic nasal caries. A small straight graft had been cut from the tibia and inserted into a tunnel in the glabella and nasal cartilage. Unfortunately the septum was almost completely absent. The periosteum had been left on the bone in order to permit the outward growth of the bone. The Wassermann test had failed to yield a reaction.

Dr. C. A. Thelander suggested the use of paraffin to raise the bridge of the nose. Paraffin, however, was uncertain material for this purpose. Dr. Dixon was congratulated by the members on the success he had attained in this case.

Dr. Dixon next showed three patients with fractured femora. The treatment in the first, a child of 18 months, was by vertical extension. The second patient was six years of age. The limb had been placed on a Thomas's knee splint. The third patient had been treated by means of Mr. Hamilton Russell's triangle of forces method. Dr. Dixon regarded this method as very interesting, although he had had little experience of it. He preferred the Thomas's splint for ordinary work and the vertical extension for infants.

Dr. McDonald stated that he had been Mr. Russell's house surgeon when the method was being worked out. He regarded it as an ideal method for securing comfort and good results. It required scrupulous care from the house surgeon. It was not uncommon for the house surgeon to be compelled to re-apply the adjustments completely twice in one day; this was sometimes necessary even three times in one day.

Dr. J. L. Selwood had treated a case of fracture of the femur in an infant at birth by vertical extension. The result had been good and the child had learned to walk.

Dr. C. A. Thelander stated that he preferred vertical extension to other methods.

Dr. A. T. Nisbet showed three skilograms, illustrating Pott's disease of the spine, a pituitary tumour and a congenital dislocation of the hip.

Dr. J. L. Selwood recorded a case of the rupture of the umbilical cord with prolapse of small intestine, large intestine and part of the liver. He had replaced the prolapsed organs with little anticipation of a satisfactory result. The opening had been closed with a purse-string suture. The operation occupied about thirty minutes. To his surprise the child had recovered without untoward signs. The motions became normal within two days. The members congratulated Dr. Selwood on the result obtained.

It is with regret that we have to announce the death of Dr. Francis Charles Somerset Adams, which took place at Orange, New South Wales, on March 29, 1921. Dr. Adams, who was in his 46th year, was a graduate of the University of Sydney and practised in Dubbo for a number of years. He enlisted for war service in 1916 and served with the Australian Imperial Force. He was invalided home in 1917 on account of pulmonary tuberculosis.

THE FEDERAL DEPARTMENT OF HEALTH.

The following is reproduced from the *Commonwealth of Australia Gazette*, No. 26, of March 19, 1921:

Quarantine, Administrative Division.

Creation of New Position.—A Director-General of Health and Director of Quarantine, Administrative Division.

Abolition of Position.—Director of Quarantine, Class A, Professional Division, Quarantine Branch, Department of Trade and Customs.

Appointment.—Dr. J. H. L. Cumpston to the position as Director-General of Health and Director of Quarantine, Administrative Division, Department of Health, from 7th March, 1921.

Transfers.—All officers at present occupying positions in the Quarantine Branch of the Department of Trade and Customs, with their positions, to the Department of Health.

W. MASSY GREENE,
Minister for Health.

The undermentioned medical practitioners of the Department of Public Health have been appointed Commonwealth Medical Inspectors of Shipping for the purposes of the Navigation Act 1912-1920:

- Dr. George Albert Blumer.
- Dr. Frank Elton Cox.
- Dr. John Simeon Colebrook Elkington.
- Dr. Mervyn John Holmes.
- Dr. Frank McCallum.
- Dr. Arthur John Metcalfe.
- Dr. Clarence James Middleton.
- Dr. Paul Wanostrocht Mitchell.
- Dr. Gerald Aubrey Murray.
- Dr. Charles Leslie Park.
- Dr. Frank William Augustus Ponsford.
- Dr. Charles William Reid.
- Dr. William Campbell Sawers.
- Dr. Frederick Tooth.

THE OPTICIANS BILL OF WESTERN AUSTRALIA.

It will be remembered by readers of *The Medical Journal of Australia* that a bill entitled the *Opticians Bill* was introduced into the Legislative Council in November of last year and that the bill was read a second time on November 23, 1920. The bill was then referred to a select committee of the House. The Chairman of the committee applied on several occasions for an extension of time for submitting the report. On December 23, 1920, the committee submitted two reports, one signed by the Chairman, the Honourable J. Nicholson, and a minority report, signed by the Honourable A. J. H. Saw. The majority report contained a recommendation that the Bill be withdrawn and a new bill be introduced in its place. The new bill should be drafted on the lines of the *Opticians Act* of Queensland (1917) with the addition of a sub-clause prohibiting the examination of the eyesight of children under the age of 16 years by anyone other than a registered medical practitioner.

The Honourable A. J. H. Saw admitted that a measure on the lines of the majority report would be less harmful than the original bill. He found, however, that it was undesirable to create a close corporation with a professional status for opticians. After dealing with the necessity for employing a mydriatic for the purpose of estimating an error of refraction in a young person, he claimed that the proposal of the majority to prohibit the testing of sight of persons under the age of sixteen years did not go far enough. He would advocate the substitution of the age of twenty.

"The evidence of the oculists showed that some opticians already exceeded their proper function of sight testing by advising patients who were suffering from diseases of the eye; and the fear they expressed that under this Bill this evil would be accentuated with results disastrous to the public, is, in my opinion, justified." Dr. Saw held that the harm stated to have been done under the existing conditions as a result of the non-registration of opticians had been much exaggerated. He suggested as an alternative to the bill for the registration of opticians that the opticians should combine to raise their standard of efficiency and that increased facilities should be afforded at the Perth Public Hospital and at the Children's Hospital for the gratuitous testing of the sight of persons in necessitous circumstances by qualified oculists.

The Honourable J. Nicholson moved the adoption of the majority report. The Honourable A. Sanderson, however, moved the "previous question." The House approved of this method of removing an objectionable measure.

A TRADE UNION AWARD FOR NURSES.

The nursing profession in Queensland is in imminent danger of setting its house on fire. The first steps of the incendiary movement have been taken, while the actual burning is timed about three weeks hence. A short time ago some busy bodies, presumably including some nurses not attached to hospitals and some young women in training, formed a trade union under the name of the Queensland Nurses' Association, with the ostensible purpose of securing better terms for the members of the nursing profession and for candidates for admission to that profession. This society has secured registration. It is questionable whether the title is descriptive. A nurses' association would be limited to nurses. This trade union seems to include students. We would further point out that the application which it has made to the Industrial Arbitration Court for an award, has obviously been drawn up by a professional trade union organizer without any real knowledge of hospital or private nursing and without any consideration for the public weal. It is obvious to anyone intimately acquainted with the working of hospitals that the effect of an award on the lines of the application would be the closure within three months of the majority of the public and private hospitals in Queensland, the unemployment of the majority of private, general and obstetrical nurses and irreparable damage to the Queensland public. In the first place the wages suggested for trainees and nurses are excessive. The young woman who thinks that she would like to become a nurse, enters a hospital, not necessarily recognized as a training school, and is to command a salary of £52, together with board and lodging, uniform and laundry. No premiums are to be paid. The young woman without any idea of her future profession, often with scant education, is to find a bed of roses. She is not to work more than 48 hours in any week. Her daily duty is not to exceed an eight-hour shift with a clear 45 minutes' interruption for each meal. She is to be paid an extra 50% for all work undertaken after the completion of the daily eight hours. For night duty she is to receive double pay.

Similar provisions are suggested for nurses, staff nurses, sisters, assistant matrons and matrons; their salaries are proportionately high. Furthermore, a trainee or nurse may break as much as she pleases when she loses her temper without being held responsible.

The professional meddler would stipulate the number of trained nurses employed in public and private hospitals. Even in private obstetrical work there would be three shifts with overtime payable for night duty. The provisions are so weird that we have difficulty in believing that they represent a serious application to a court of law. If the wording is to be interpreted literally, we fail to understand how any patient could receive nursing attention from a nurse. Clause 18 reads:

The duties of a nurse and trainee shall not include that of the work of a maid or waitress.

That the whole matter is not a practical joke is demonstrated by the information that the Queensland Branch of the British Medical Association has notified the Court that it proposes to give evidence when the application is

being considered. We anticipate that the representatives of the Branch will have little difficulty in persuading the Court that the application is unworkable, that the situation which would be created by such an award, would be confused and that the whole idea of governing the nursing profession on trade union principles is a hare-brained delusion.

A PORTRAIT OF PROFESSOR J. T. WILSON.

There is no memorial of the work done for the Medical School of the University of Sydney by Professor J. T. Wilson, F.R.S., except in the repute of the School and the careers of its students. Nothing can be better than these. Yet more is required for the sake of future generations. The University staff formed a "New Portraits Fund" a short time ago for the purpose of obtaining the portrait of Professor Wilson, with those of Professor Sir Edgeworth David, F.R.S., and the Warden, Mr. H. E. Barff. The idea was a happy one and will result in the adequate commemoration of three great careers aggregating a century of service to Australia and to the University of Sydney. The University Medical Society had already determined to place a portrait of Professor Wilson in the collection in the Great Hall. Finding that the staff had also thought of doing the obvious thing, the Medical Society is now making common cause with all graduates and friends of the University grouped in the "New Portraits" movement. Medical graduates will be asked to insure its success. The total amount required is about £1,000, of which half is in hand. Professor Wilson's portrait is expected to cost 300 guineas with the addition of freight, insurance and duty. He will select the artist.

Medical Appointments.

Dr. James E. Mahon has been appointed Resident Medical Officer to the Adelaide Hospital.

It is announced that Dr. H. B. Kershaw (B.M.A.) has been appointed Medical Officer to the Venereal Clinic at the Fremantle Public Hospital.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xx.

Public Service Board, Sydney: Three Junior Medical Officers for Mental Hospitals.

Sydney Hospital: (a) Honorary Assistant Surgeon, (b) Hon-

orary Operating Dentist.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

| Branch. | APPOINTMENTS. |
|--|---|
| NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.) | Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phoenix Mutual Provident Society. |

| Branch. | APPOINTMENTS. |
|---|--|
| VICTORIA. (Hon Sec., Medical Society Hall, East Melbourne.) | All Institutes or Medical Dispensaries. Manchester Unity Independent Order of Oddfellows. Ancient Order of Foresters. Hibernian Australian Catholic Benefit Society. Grand United Order of Free Gardeners. Sons of Temperance. Order of St. Andrew. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association. |
| QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.) | Australian Natives' Association. Brisbane United Friendly Society Institute. Stannary Hills Hospital. |
| SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.) | Contract Practice Appointments at Remark. Contract Practice Appointments in South Australia. |
| WESTERN AUSTRALIA. (Hon. Sec., 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.) | All Contract Practice Appointments in Western Australia. |
| NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.) | Friendly Society Lodges, Wellington, New Zealand. |

Diary for the Month.

- Apr. 12.—Tas. Branch, B.M.A.
- Apr. 12.—N.S.W. Branch, B.M.A., Ethics Committee.
- Apr. 14.—Vic. Branch, B.M.A., Council.
- Apr. 15.—North-Eastern Med. Assoc. (N.S.W.), Annual.
- Apr. 19.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
- Apr. 20.—W. Aust. Branch, B.M.A.
- Apr. 22.—Q. Branch, B.M.A., Council.
- Apr. 22.—Western Med. Assoc. (N.S.W.).
- Apr. 26.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
- Apr. 27.—Vic. Branch, B.M.A., Council.
- Apr. 28.—S. Aust. Branch, B.M.A..
- Apr. 29.—N.S.W. Branch, B.M.A..
- May 4.—Vic. Branch, B.M.A..
- May 6.—Q. Branch, B.M.A..

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated. All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, (Telephone; B. 4635.)